
Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide

# *Sex Offender Programming in Youth Correction and Detention Facilities*

Office of Juvenile Justice and Delinquency Prevention
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CJCA
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# Juvenile Sex Offender Programming:

# A Resource Guide

**Prepared by:**

**David Berenson**
**Director of Sex Offender Services**
**Ohio Department of Rehabilitation and Correction**

**Lee Underwood, Psy.D.**
**Program Consultant**
**The National GAINS Center for**
**People with Co-occurring Disorders in the Justice System**

**With assistance from:**

**Council of Juvenile Correctional Administrators**
**Edward J. Loughran, Executive Director**
**Kim Godfrey, Assistant Director**
**Stacy Stoddard, Research Assistant**

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**SEX OFFENDER PROGRAMMING IN JUVENILE CORRECTION AND DETENTION FACILITIES**

## I. **Introduction:**

In 1995, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) awarded the Council of Juvenile Correctional Administrators a major grant to develop, field test and implement performance-based standards for juvenile correction and detention facilities. OJJDP recognized that existing standards failed to assure that critical outcomes related to safety, security, order, health, education and other programming were being achieved. The Performance-based Standards project offers a systematic method for facilities to measure outcomes and offers ways for facilities to review their operations and make improvements.

One of the many components of the project is to develop and distribute a series of seven Resource Guides to assist facilities with the development or improvement of special programs or program components. These guides are designed to be a handy reference that review the background of the problem, provides a model of an ideal program, briefly summarizes research used to develop programs, lists existing programs with evaluation information as well as organizations, Internet sites and additional written materials.

Each of the guides is designed to provide facility staff and administrators with a readable and thorough summary of current information and profiles of programs that appear promising. The guides are based on expert knowledge, input from leaders in the field and a review of research and resources available. The guides are not meant to be definitive sources but a resource to help make improvements.

## II. Background

Sexual abuse and sexual assault continues to be a serious concern in today's society. The increasing number of youths arrested for sexual offenses has served to deepen this concern. Until the late 1970's, the conventional wisdom was that only adult males committed sexual assaults. The public's view and awareness of this issue changed as new data became evident. Studies from the 1980's indicate that 20% to 30% of rapes committed in this country each year and 30% to 60% of the cases of child sexual abuse were perpetrated by juveniles (Brown, Flanagan, & McLeod, 1984; Fehrenbach, Smith, Monarstersky, & Deishner,1986). FBI data indicate that in 1995, 15.8% of arrests for forcible rape and 17% of arrests for all other sex offenses involved youth under 18 years old (cited in Sipe, Jensen, & Everett, 1998). Studies of adult offenders suggest that approximately half of these individuals began their sexually abusive behavior before adulthood (Abel, Mittelman, & Becker, 1985; Groth, Longo, & McFadin, 1982, Center for Sex Offender Management, 1999). Furthermore, these studies indicate that these youth offended in a wide range of sexual misconduct.

The problem of juvenile sex offending has led to the tremendous growth of treatment programs over the past 17 years. In 1982, Safer Society Press reported that only 20 treatment programs for juvenile sex offenders had been identified in the United States. These included a range of programming from institutional and residential to community-based outpatient treatment. By 1993, Safer Society reported that there were more than 800 programs for juvenile sex offenders.
The number of programs has continued to expand throughout the 90's. There is, increasingly, the expectation of the courts, prosecutors, defense attorneys, and victims that juvenile sex offenders will receive treatment when they are placed in juvenile correctional facilities.

Juvenile corrections contributed significantly to the design and development of juvenile sex offender programs in the late 1970's and early 1980's. Safer Society Press published the first descriptions of juvenile sex offender programs in 1982 in Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions. Four of the programs, cited in this book, were run in juvenile correctional institutions. These were grass roots programs, developed to meet a new and pressing need in juvenile corrections: the rapid and expanding influx of adolescent sex offenders. In chapter one, the author, Fay Honey Knopp, writes,

> Little attention was devoted to the sexually abusive adolescent until quite recently, but new and compelling developments during the last decade make it difficult to continue to ignore the reality of sexual aggression in this age group. Programs for adult sex offenders multiplied in the seventies. Stunning information about youthful sex offenses emerged as rapists and child molesters shared their personal histories in autobiographical materials and groups sessions. Life stories usually began with descriptions of their pubertal or

prepubertal sex offenses, confirming what some sex offender specialists had surmised: the behavior of a significant number of serious adult sex offenders is patterned essentially on acts that usually begin soon after puberty.

Programs serving child and adult victims of sexual abuse proliferated as well during this period. The victim programs identified and reported significant numbers of assailants under age 18. Communities thus were confronted, not with abstract statistics, but with the more vivid realities of their own youth—neighbors, sons, brothers, and babysitters—who had molested and raped, peeped and flashed. [1]

Adolescent sex offender treatment is considered to be tertiary prevention. The 1993 National Task Force Report refers to the community as the primary client of treatment. Public safety and victim protection are the fundamental goals of sex offender intervention. It has been said that treatment providers are "the voices of the victims". Understanding that many adult sex offenders began committing acts of sexual abuse in their pubescent years, adolescent sex offender treatment is viewed as a means to prevent these individuals from committing sex offenses in the future.

Juvenile corrections plays a central role in systems across the country that provide a continuum of services and treatment options for adolescent sex offenders. In society's attempts to deal with the intractable problem of sexual abuse and sexual assault, corrections is the necessary venue of last resort. As such, staff working with sex offenders in juvenile correctional facilities and supervising sex offenders on probation and parole, are dealing with youth who have committed serious, and in some cases, heinous sex offenses. These staff understand that the youth, as juveniles, will be released as young adults and that every effort must be made to prevent sexual re-offending.

**Types of Juvenile Sex Offenders**

In 1986, the first juvenile sex offender typology was presented by O'Brien and Bera. This typology categorized sex offenders into the following seven types:

1. Naïve Experimenters
2. Undersocialized Child Exploiters
3. Sexual Aggressives
4. Sexual Compulsives
5. Disturbed Impulsives
6. Group Influenced
7. Pseudo Socialized.

[1] Knopp, F.H., (1982). Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions, Orwell, VT: Safer Society Press, (pp.4-5).

The O'Brien Typology was widely accepted in the field, as the categories seemed to reflect the personality types of sex offenders being treated by clinicians. There appeared to be an experiential basis in validating these categories. However, systematic studies of this typology find its reliability and validity to be lacking. More recent efforts in the field have attempted to utilize sex offender classification schemes validated on adults (Knight and Prentky, 1993) in differentiating juvenile offenders.

Hunter (1998) purports a simpler typology for juvenile sex offenders that differentiates two major types: those who offend against children and those who offend against peers or adults. Child offenders are those who aggress against children five or more years younger than themselves. Hunter presents the following table to examine the differing features of these two types of juvenile sex offenders.

**Comparing Two Sub-Groups of Juvenile Sex Offenders**

| ***Characteristics:*** | ***Offend Against Peers or Adults*** | ***Offend Against Children*** |
|---|---|---|
| ***Victims*** | • Predominantly assault females.<br>• Mostly strangers or acquaintances. | • Females victimized at slightly higher rates.<br>• Nearly half have at least one male victim.<br>• Up to 40% of victims are either siblings or relatives. |
| ***Offense Patterns*** | • More likely to commit in conjunction with other criminal activity.<br>• More likely to commit offenses in public areas. | • Reliance on opportunity and guile, particularly when victim is a relative.<br>• Trick child by using bribes, or threatening loss of relationship. |
| ***Social and Criminal History*** | • More likely to have histories of non-sexual criminal offenses.<br>• Generally delinquent and conduct-disordered. | • Deficits in self-esteem and social competency are common.<br>• Often lack skills and attributes necessary for forming and maintaining healthy interpersonal relationships. |
| ***Behavior Patterns*** | • Display higher levels of aggression and violence.<br>• More likely to use weapons and cause injuries to their victims. | • Frequently display signs of depression.<br>• Youths with severe personality and/or psychosexual disturbance may display high levels of aggression and violence.<br>• May evidence less indifference towards others. |

It is important to note that only a minority of juvenile sex offenders present ingrained patterns of paraphiliac arousal and sexual interest. In a review of youth committed for sex offenses to the Ohio Department of Youth Services, 10% to 12% of sex offenders manifest such ingrained arousal patterns. Oftentimes, children—in babysitting situations and siblings—are victims of opportunity. The offenders have easy access to these children and act out patterns of power, control, and anger in the victimization of the children. Hunter writes:

> These arousal and interest patterns are recurrent and intense, and relate directly to the nature of the sexual behavior problem (e.g., sexual arousal to young children). Deviant arousal is more clearly established as motivator of adult sexual offending, particularly as it relates to pedophilia. A small subset of juveniles who sexually reoffend against children may represent cases of early on-set pedophilia. Research has demonstrated that the highest levels of deviant sexual arousal are found in juveniles who exclusively target young male children. In general, the sexual arousal patterns of juvenile sex offenders appear more fluid than those of adult sex offenders, and relate less directly to their patterns of offending behavior. [2]

Sibling offenders are quite prevalent, as they perpetrate the greatest number of abusive acts. In fact, they may present the most serious problems in terms of the extent and nature of their offending patterns. O'Brien (1991) compared 170 youths who sexually offended against siblings (including step-siblings, half-siblings, and adoptive siblings) with those who offended against extrafamilial children and with those who victimized peers or adults. His findings are represented in the following graph:

| | ***Offended Against Siblings*** | ***Offended Against Extrafamilial Children*** | ***Offended Against Peers or Adults*** |
|---|---|---|---|
| ***Average number of abusive acts per youth*** | **18** | **4.2** | **7.4** |
| ***Number of youths offending for more than one year*** | **76** | **39** | **41** |
| ***Number of youths committing vaginal or anal rape*** | **78** | **48** | **22** |

[2] Hunter, J. (1998). Understanding Juvenile Sex Offenders: Emerging Research, Treatment Approaches, The Center for Sex Offender Management, (p.4).

## Female Sex Offenders

Although less than 10% of all persons arrested for sex offenses are female, this figure represents 7,000 reported cases of sex offenses per year (Federal Bureau of Investigation, 1991). Finkelhor and Russell (1984) suggest that as many as 20% of male victims and 5% of female victims of sexual abuse have been victimized by women. The number of adolescent females arrested for sex offenses rose 31.5% between 1980 and 1990 (Federal Bureau of Investigation, 1991). Statistics from the Office of Juvenile Justice and Delinquency Prevention (1992) indicate that females committed 2% of forcible rapes perpetrated by juveniles and 7% of other sex offenses perpetrated by juveniles, involving approximately 1,500 adolescent female sex offenders.

Despite the significance of female sex offenders, there is a paucity of empirical studies on this population, with adolescent offenders receiving the least attention. This lack of literature is further exacerbated by the small sample sizes of existing studies (Fehrenbach and Monastersky, 1988, Hunter et al., 1993, Bumby and Bumby, 1993, Bumby, et al., 1996). Bumby and Bumby (1997) reviewed the literature regarding adolescent female sex offenders, suggesting the following findings:

- Adolescent female offenders tend to commit multiple acts of sexual abuse against younger family members, often in caregiving situations.
- They tend to be of average intelligence but experience academic and behavioral problems in school.
- They oftentimes engage in a variety of delinquent behaviors, including substance abuse.
- They suffer from emotional and psychological difficulties, evidenced by suicide attempts, anxiety, depression, and Post Traumatic Stress Disorder.
- They oftentimes come from unstable homes where they may be numerous forms of abuse and maltreatment.
- They tend to have high rates of sexual victimization themselves. In many cases they have been victimized by more than one offender. The abuse usually begins at an early age and happens on multiple occasions.

## Assessment

A comprehensive sex offender-specific assessment must be completed when the offender first enters the system (National Task Force on Juvenile Sex Offending, 1993). This assessment serves as the basis for program placement and a comprehensive treatment plan. This assessment includes a detailed record review, structured clinical interviewing, the administration of psychometric instruments related to personality adjustment and functioning, and the administration of specialized instruments designed to assess sexual attitudes and interests. It is important that the clinician conducting the assessment review the following records: victim statement(s), police reports, juvenile court records, mental health records, and school records. These records

should be carefully studied before a clinical interview is done. Sex offenders' statements are completely unreliable, as they lie and distort any information regarding their offenses. Thus the clinician must be as familiar as possible with the facts of the case and functioning of the offender before the interview.

An important aspect of the comprehensive assessment is the administration of a risk assessment. This assessment yields a designation of high, moderate, or low risk. In juvenile correctional systems, these designations are important in determining program placement. High risk offenders should be targeted for the most intensive programming. Prentky et al. (2000), in the Juvenile Sex Offender Assessment Protocol (J-SOAP), have identified the following domains for juvenile sex offender risk assessment:

- Sexual drive / preoccupation
- Duration of sex offense history
- Impulsiveness / antisocial personality functioning
- History of expressed anger
- History of substance abuse
- Level of denial
- Internal motivation for change
- Evidence of empathy, guilt, and remorse
- Presence of cognitive distortions
- Community Stability / Adjustment (in the community six months prior to commitment).

Dougher (1996) cites the importance of evaluating information regarding the specific offense(s) committed by the sex offender, addressing issues regarding the nature of the offense(s), victim characteristics, and antecedents of the crime(s). Previous offenses should be explored, documenting patterns related, again, to victim characteristics and offense antecedents. Dougher outlines the following set of factors to be evaluated:

- Level of psychopathology
- Developmental history
- Educational history
- Social history
- Religious beliefs
- Occupational history (whenever applicable, usually to young adults)
- Level of anger
- Level of responsibility and ability to empathize
- Awareness of emotion
- Cognitive distortions about men, women, and children
- Sexual arousal.

The following tests, screens, and inventories, are commonly utlilized in juvenile sex offender assessments:

- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
- Psychopathy Checklist: Youth Version (PCL:YV)
- Youth Level of Service / Case Management Inventory (YLSL)
- Multidimensional Assessment of Sex and Aggression (MASA)
- Wilson Sexual Fantasy Questionnaire
- Multiphasic Sex Inventory (MSI)
- Abel and Becker Card Sort
- Abel Assessment for Sexual Interest
- Abel and Becker Cognitions Scale
- Burt Rape Myth Accpetance Scale
- Buss / Durkee Hostility Inventory

Polygraphy has been increasingly utilized in the assessment of juvenile sex offenders for the purpose of facilitating more complete disclosures of sexually aggressive behaviors. The National Task on Juvenile Sex Offending notes, however, that polygraph examinations must be voluntary and require the full informed consent of the youth, parent, or guardian.

In its final form the assessment presents a detailed picture of the offender. This picture informs others as to the potential risk of the offender, while making sense of those issues and factors in his life that contribute to that risk. By viewing the picture in its totality, and by examining those specific issues and factors, clinicians and correctional staff can determine a plan of action, intended to decrease the level of risk to sexually reoffend.

## Treatment

### *An Overview*

The National Task Force on Juvenile Sex Offending was established in 1986 and published its findings in its final report in 1993. The ostensible purpose of the Task Force was to develop standards for the assessment and treatment of juvenile sex offenders. Given the fact that sufficient research did not exist to support standards, the Task Force presented a set of assumptions that reflected the most current thinking in the field.

Righthand (1999) summarizes these assumptions as follows:

Following a full assessment of the youth's risk factors and needs, individualized

and developmentally sensitive interventions are required. Individualized treatment
plans should be designed, reassessed, and revised periodically. They should specify treatment needs, treatment objectives, and required interventions. Treatment
should be provided in the least restrictive environment necessary for community protection. Treatment efforts also should involve the least intrusive methods that can be expected to accomplish treatment objectives. Written progress reports should
be issued to the agency that has mandated treatment and discussed with the youth
and parents. Progress "must be based on specific measurable objectives, observable
changes, and demonstrated ability to apply changes in current situations" (p. 53). Although adequate outcome data appear lacking, the National Adolescent Perpetrator
Network (1993) suggests that satisfactory treatment will require a minimum of 12 to 24 months. [3]

The Task Force identified 22 treatment goals to be addressed in treating the adolescent sex offender. The report was emphatic in stating that the primary goal of adolescent sex offender treatment is community safety. Thus these 22 treatment goals must be understood as a means to achieve the primary goal of community safety. The list of goals follows:

1. Acceptance of responsibility for behavior without minimization or externalizing 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 (i.e., sexual abuse, sexual trauma, physical abuse, emotional abuse, physical abuse, abandonment, rejection, loss, etc.).
5. Development of victim awareness/empathy to a point where potential victims are seen as people rather than objects.
6. Development of an 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 positive sexual fantasy.
9. Understanding the consequences of offending behavior for the self, the victim, and their families in addition to developing victim empathy.

[3] Righthand, S., & Welch, C. (1999). Youths Who Have Sexually Offended: A Review of the Professional Literature, Unpublished manuscript, (p.43).

10. Identification (and remediation to the extent possible) of family issues or dysfunctions which support or trigger offending: attachment disorders and boundary problems in families.
11. Identification of cognitive distortions, irrational thinking or thinking errors which support or trigger offending.
12. Identification and expression of feelings.
13. Development of pro-social relationships 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. Resolutions of substance abuse and / 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. [4]

It should be noted that, although the Task Force report was published in 1993, its basic content had been developed and published in a preliminary report in 1988. These treatment goals have set the context for adolescent sex offender treatment. Throughout the decade of the 90's clinicians and program providers have refined and consolidated these treatment goals. Hunter (1998) lists the following essential components of the treatment process:

- Establishing positive self-esteem and pride in one's cultural heritage.

- Teaching and clarifying values related to respect for self and others, and a commitment to stop interpersonal violence. The most effective programs promote a sense of healthy identity, mutual respect in male-female relationships, and a respect for cultural diversity.

- Providing sex education to give an understanding of healthy sexual behavior and to correct distorted beliefs about appropriate sexual behavior.

- Enhancing social skills to promote greater self-confidence and social competency.

- Teaching the impulse control and coping skills needed to successfully manage sexual and aggressive impulses.

[4] National Adolescent Perpetrator Network (1993). The Revised Report of the National Task Force on Juvenile Sex Offending, The Juvenile and Family Court Journal, 44 (4), (p.44).

- Teaching assertiveness skills and conflict resolution skills to manage anger and resolves interpersonal dispute.

- Programming designed to enhance empathy and promote a greater appreciation for the negative impact of sexual abuse on victim and their families.

- Provisions for relapse prevention. This includes teaching offenders to understand the cycle of thoughts, feelings, and events that can trigger sexual acting out, identify environmental circumstances and thinking patterns that should be avoided because of increased risk of reoffending, and identify and practice coping and self-control skills necessary for successful behavior management. [5]

In designing approaches and interventions to accomplish these goals and implement these components, clinicians treating sex offenders discovered that conventional mental health and psychotherapeutic approaches did not work. In fact, they could serve to exacerbate the offending by enabling behavior. It became clear in the late 70's and early 80's that nondirective psychotherapy and the traditional mental health mindset put the offender in control and supported the denial and minimization of his offending behavior. It became clear that offender accountability must be established at the very beginnings of sex offender treatment, setting the stage the National Task Force assumption that the community is the primary client of treatment.

Treatment of the sex offender begins with establishing accountability in working with the offender to accept responsibility for his behavior. Some clinicians believe that treatment starts in the courtroom when the offender is held accountable by the court by virtue of the conviction for
the sex offense. Unlike traditional mental health treatment, the courts and criminal justice and juvenile justice systems are necessary collaborators in the treatment process. Without the support of these systems and the sanctions they have available, sex offender treatment, in most cases, would be impossible. Sex offenders are highly resistant to treatment. They do not present themselves for treatment, believing that they have problems that require resolution. They externalize responsibility, blaming others for the trouble they have gotten into.

Barbaree and Cortoni (1993) consider the reduction of denial and minimization and the development of victim empathy to be the necessary "first step" in developing the offender's motivation for treatment and subsequent behavior change. Denial and minimization are common features of the sex offender's personality functioning. They pose serious barriers to treatment and can create frustration in clinicians and staff working with sex offenders. This is particularly evident in correctional settings, where the more serious offenders are placed. Thus dealing with denial and minimization

[5] Hunter, J. (1998). Understanding Juvenile Sex Offenders: Emerging Research, Treatment Approaches, The Center for Sex Offender Management, (p.10).

requires the implementation of highly structured interventions. These interventions must be implemented persistently, confronting the offender with the harm he has caused other people.

The development of victim awareness and victim empathy are essential elements in this "first step" in developing the offender's motivation for treatment. One of the key strategies used in breaking down denial and minimization is to assist the offender in developing an awareness of the effects of his behavior on his victims. The offender implements a series of exercises, through which he can develop an understanding of the personal consequences of his abusive acts for his victim(s). However, accurate perceptions of victimization do not necessarily lead to the development of victim empathy, i.e., an internalized capacity to project oneself into the victim's experience and perceptions of the abusive behavior. Thus specific work must be done to move the offender from a view of life that shuts out compassion for victim(s) to one in which he responds to them with care and compassion. Without the capacity for victim empathy (at least at a cognitive level), victim awareness may have negligible impact.

The most commonly used treatment modalities in sex offender treatment are individual, group, and family interventions. Group therapies are the modalities of choice, as they are the most economical and efficient. It should be noted, however, that there is no scientific evidence that groups are more effective than other modalities. It is recommended that groups be run by male and female co-therapists, although again, there is no scientific support for this. Groups can be particularly effective in correctional settings, as they provide staff with a structured, scheduled arena in which to examine not only the offenders' sex offender treatment issues, but the thinking, behavior and relationships occurring in the facility on a daily basis.

***Psychoeducation***

Psychoeducational modules are oftentimes used in sex offender programs. They utilize educational approaches to providing offenders with information in a variety of areas. Following are examples of the areas these modules cover:

Victim Awareness
Sex Education / Positive Human Sexuality
Anger Management
Stress Reduction
Social Skills Training
Assertiveness Training
The Sexual Assault Cycle
Substance Abuse
Cognitive Restructuring.

Psychoeducational modules are used as an ancillary treatment strategy that supports and enhances the offender's daily work on treatment goals and objectives. The modules are written as lesson plans and are presented in a didactic format. These modules provide information and knowledge to be utilized in group therapy and homework assignments. Teaching accurate information and knowledge in areas such as sex education and victim awareness clarifies misconceptions and dispels certain myths that support and encourage abusive behavior. Importantly, there is a skill-building regimen in many of the modules, e.g., social skills and assertiveness training that equip the offender with pro-social strategies to replace delinquent, criminal, and other dysfunctional behavioral repertoires.

***Relapse Prevention***

Relapse prevention is the most widely embraced model in adult and juvenile sex offender treatment. Initially, relapse prevention was developed in the addictions field to prevent the reoccurences of substance abuse, smoking, and eating disorders. Pithers, Marques, Gibat, and Marlatt (as cited in Barbaree and Cortoni, 1993) adapted this model to the treatment of adult sex offenders. In the 80's clinician's in the juvenile sex offender treatment field applied relapse prevention to juvenile populations.

Relapse prevention asserts that "there is no cure" and "maintenance is forever." Offenders learn to identify antecedents to sexually deviant behavior, as well as key factors that trigger this behavior. The antecedents, or precursors, are alterations in personality functioning that eventuate in sexual deviance. These antecedents involve changes in affect, deviant sexual fantasies, thinking errors, cognitive distortions, and offense planning. For example, a rapist chronically experiences anger reactions to situations in his environment which he can not control, or get in the way of what he wants. Oftentimes, the anger—a functional alteration or antecedent—stimulates sexually deviant fantasies, the next in a series of functional of alterations. Thinking errors (e.g., the absence of empathy, ownership thinking—believing that whatever he wants belongs to him, criminal pride—believing that he is No. 1 in the world and that he will never get caught, lack of a time perspective) and cognitive distortions (e.g., the victim wanted to have sex with him, the victim initiated the encounter) restructure the offender's perceptions of the world to such an extent that it makes sense, within his private frame of reference, to act out the deviant sexual fantasy. Another antecedent might be the offender's passive planning of the sexual assault. He mentally practices how he will carry out the offense. If we had a computer readout of the offender's subjective experience, we would know that a sex offense would be committed at some time, albeit we could not identify who the victim would be and when the offense would happen.

A key point in the relapse prevention model is that a sex offense is not an impulsive behavior. There are early warning signals within the offender's personality functioning. Anger in the rapist is a red flag that an internal process is underway which

could lead to sexual assault. Depression and anxiety in child molesters are red flags that indicate a risk to sexually offend. Offenders learn to identify high risk situations that can trigger strong emotional responses, setting off the pattern of internal alterations. Offenders also learn coping strategies, skills, and interventions to avoid and manage high-risk situations and to interrupt this chain or pattern of functional alterations. These interventions have been referred to as "cognitive-behavioral brakes." Offenders become so clearly aware of their internal lives that they cannot commit an assault except by a fully conscious and deliberate choice.

Understanding that offenders may very well choose to reoffend, relapse prevention deals not only with the internal dimension of change, but sets out an external framework to maintain community safety. During institutional treatment, probation and parole staff, community treatment agents, and families are implored to communicate and meet with the institutional treatment team, in an effort to provide a seamless system of service delivery from the institution back into the community. Significant others in the offender's life learn to identify the high-risk situations and warning signals so that they can attempt to interrupt the future potential of a sexual assault. Probation and parole staff, as supervisory agents, develop networks of collateral contacts with families, schools, employers and treatment providers to effectively monitor and supervise sex offenders in the community. Consistent, persistent communication, intensive supervision, and the use of polygraphs are essential features of an external framework, designed to enhance community safety.

***Cognitive-Behavioral Modification***

Cognitive-behavioral modification has a variety of connotations in sex offender treatment. This term can refer to techniques that target deviant sexual arousal patterns, approaches to restructure belief systems, self-regulation strategies, relapse prevention, and techniques to eliminate / replace criminal thinking errors, among others.

Cognitive theories of behavior change identify three basic targets for intervention: 1) the client's behaviors and the reactions they elicit in the environment; 2) the client's internal dialogue, i.e., what he silently says to himself before, during, and following the behavior; and 3) the client's cognitive structures, or beliefs, that give rise to the internal dialogue. (Meichenbaum, 1977). Thus cognitive-behavioral models of change use an array of mediational interventions that lead to new and responsible beliefs, thinking, and behavior.

One fundamental aspect of thinking is its capacity to produce an ongoing, persistent, and perpetual process of inner speech, the internal dialogue. As an internal dialogue, thinking is our way of constantly and silently "talking to ourselves". In the course of that dialogue, we tell ourselves about how we interpret events and stimuli happening in the world, how we perceive ourselves in relationship to those interpretations, how we feel about these perceptions, and what we have as options to

deal with these interpretations and perceptions. Furthermore, this inner speech, the internal dialogue, sorts out the feelings and options, finally deciding what behavior(s) will be enacted. In the final moment of perception and interpretation, a choice is made, i.e., a behavior is selected. Thus a cognitive approach to behavior change targets thinking processes as the most expedient, effective arena for intervention.

Cognitive-behavioral approaches also target the youth's underlying beliefs (cognitive structures) that give rise to the internal dialogue. The set of beliefs, or belief system that drives thinking is, in fact, the framework for the youth's view of the world. Core beliefs about oneself, society, other people, family, money, sexuality, relationships, and spirituality become foundational targets for change. As the youth identifies and alters specific patterns of thought that make up his internal dialogue, he is constantly reshaping the beliefs that frame and undergird those thoughts.

*The Thinking Errors Approach (TEA)* (Yochelson and Samenow, 1976) is an important cognitive approach to behavior change that is particularly relevant to adult and juvenile correctional populations. TEA identifies specific thinking patterns, which in given constellations, lead to criminal behavior. These thinking patterns are called *thinking errors.* Following are examples of the major thinking errors described by Samenow:

- *Victim Stance* – when the offender is held accountable for a crime or irresponsiblity, he
  portrays himself as the victim.

- *"I Can't" Attitude* – the offender refuses to do whatever he does not want to do and
  portrays himself as being incapable of doing it.

- *Lack of a Concept of Injury to Others* – the offender does not stop think about how his behavior hurts others;

- *Failure to Put Himself in the Place of Others* – the offender has little or no empathy and does not consider the impact of his action on others.

- *Attitude of Ownership* –the offender treats other people's property as though it belonged to him. A sex offender perceives another person's sexuality as a commodity that belongs to him. In this sense, a sex offense is a violent theft of another person's sexuality.

- *Exaggerated Pride* -- the offender perceives himself as being number one in all situations. He insists on his point of view to the exclusion of all others and refuses to back down, even on little points.

- *Irresponsible Decision-Making* – the offender makes erroneous assumptions, does not consider the facts, except as they support his assumptions, and blames others when things go wrong.

- *Anger* – the offender uses anger to control others. It is his chronic response to not being in control. It may take the form of direct threat, intimidation, assault, sarcasm, or annoyance.

- *Power Tactics* – the offender constantly acts to maintain the position of being number one. He attempts to overcome others in any struggle or situation. He gets high levels of excitement from overcoming and dominating people.

The essence of the Thinking Errors Approach is that the offender thinks very differently than other people, and that thinking must change if the offender is going to live a responsible life. It is a natural assumption that we believe other people basically think about things the same way we do. This is not true in reference to the offender. His thinking is based upon a private logic that assumes he must dominate and control every situation, that he is superior to others, and that he can do whatever he wants whenever he chooses to do it.

The change process requires that the offender learns to report the raw data of his thinking. Journals, thinking logs, and reflection exercises are tools through which the offender reports his thinking. He learns to identify thinking errors in group, individual counseling, and psychoeducational activities. Furthermore, he learns to implement mental correctives to eliminate the thinking errors as they become evident. One of the most powerful correctives is the moral inventory, by virtue of which he examines the harm he has caused other people. He examines the consequences of his anger for others and for his own life. He examines his basic choices in life, reviewing the outcomes of continued criminal behavior. Thus the correction of thinking processes, as the direct determinants of behavior, become the central focus of treatment. As the offender implements the mental correctives, he develops new and responsible cognitive structures (beliefs) that generate and support new and responsible thinking patterns.

***Treatment for Antisocial Juveniles***

Adolescent sex offenders committed to juvenile correctional facilities, oftentimes, have histories of committing any number of different crimes. Sex offending is just one example of criminal behavior. Meta-analytic studies, conducted in the 80's and 90's have identified major factors in social and personality functioning that must be addressed in treating delinquent and antisocial offenders. Andrews et al., 1990, Andrews and Bonta, 1994, Lipsey et al., 1998). The findings of these studies are clearly relevant to the development of sex offender programs in juvenile correctional facilities.

Andrews and Bonta (1994) identified the following major set of "risk / need factors :

- Antisocial / procriminal attitudes, values, beliefs, and cognitive-emotional states;
- Procriminal associates and isolation from anticriminal others;
- Temperamental and personality factors conducive to criminal activity including psychopathy, weak socialization, impulsivity, restless aggressive energy, egocentrism, below average verbal intelligence, a taste for risk, and weak problem-solving / self-regulation skills;
- A history of antisocial behavior evident from a young age, in a variety of settings and involving a number and variety of different acts;
- Familial factors that include criminality and a variety of psychological problems in the family of origin and, in particular, low levels of affection, caring, and cohesiveness, poor parental supervision and discipline practices, and outright neglect and abuse.

Andrews and Bonta go on to identify "promising intermediate targets for rehabilitative programming:

- Changing antisocial attitudes
- Changing antisocial feelings
- Reducing antisocial peer associations
- Promoting familial affection / communication
- Promoting familial monitoring and supervision
- Promoting identification / association with anticriminal role models
- Increasing self-control, self-management and problem-solving skills
- Replacing the skills of lying, stealing, and aggression with more prosocial alternatives
- Reducing chemical dependencies.

Importantly, Andrews and Bonta discuss approaches that do not work, including programs that involve intense group interaction without gaining control over the contingencies, non-directive client-centered counseling, unstructured psychodynamic, and variations on themes of official punishment. They also identify less promising targets for rehabilitative programming:

- Increasing self-esteem (without simultaneous reductions in antisocial thinking,
  feelings, and peer associations);
- Focusing on vague emotional / personal complaints that have not been linked with criminal conduct;
- Increasing the cohesiveness of antisocial peer groups;

- Improving neighborhood-wide living conditions, without touching the criminogenic need of the higher risk individuals;
- Showing respect for antisocial thinking on the grounds that the values of one culture are as equally valid as the values of another culture;
- Attempting to turn the client into a "better person," when the standards for being a "better person" do not link with recidivism.

A meta-analysis of rehabilitation programs designed for juvenile delinquents (Izzo and Ross, 1990) found that programs based on cognitive therapy were twice as effective as those that used other approaches. They defined cognitive therapy as those that utilized one or more of six intervention modalities: problem-solving, negotiation skills training, interpersonal skills training, rational-emotive therapy, role-playing and modeling, and cognitive-behavior modification. In the most current meta-analytic current study, Lipsey and Wilson (1998) found treatments that targeted interpersonal skills (e.g., social skills training, anger management, moral education) and utilized behavioral programs consistently produced the most positive effects.

***Special Needs Offenders***

Special needs sex offenders present problems and needs that require specialized intervention and treatment services. Two of the most significant subpopulations are offenders with comorbid pscyhological disorders and those with developmental disabilities. The initial screening and comprehensive assessment process identifies these types of special needs offenders, so that treatment planning and program placement can address the special needs.

Prescribed psychological and psychiatric interventions must be integrated into the treatment regimen of offenders with serious mental illness. It is important that treatment agents collaborate with psychologists and psychiatrists for the purpose of treating and managing the mental illness. Some correctional systems provide separate housing units for these youth. There are less youth on these units, and there is more individual interaction.

Sex offenders with developmental disabilities require remediated interventions. The goals, objectives, and content of treatment are similar to that of other sex offenders, however, their learning style must be addressed. Factors and adaptations to be considered in developing programming for these offenders are:

- Their attention span may be shorter.
- Their understanding is concrete and literal.
- Their retention and memory is low.
- Learning is internalized through experiential events and exercises.
- Comprehension is heightened by using one style of presentation at a time.

- Teaching and counseling must be slowed down to give them time to think about what is being presented.
- Program materials must be simplified and presented using drawings, pictures, labels, etc.

***The Treatment Setting***

A major issue in treating juvenile sex offenders in any residential setting, including juvenile correctional centers, concerns the safety of residents. In planning and implementing sex offender programs specific measures and procedures must be developed to facilitate safety in the treatment settings. These measures and procedures are also designed to reduce the likelihood of sexual acting out behaviors. Juvenile sex offenders, in residential and correctional settings, present serious problems in terms of sexual acting out. Such behavior can become widespread and chronic in facilities. This problem exists, to some degree, with non-sex offending populations; however, it can become a rampant problem in juvenile sex offender populations.

The National Task Force Report in 1993 provided specific recommendations to facilitate safety in residential treatment facilities. The report states that programs should ensure the following:

1. A systems based program design for sexual abuse prevention in the institutional setting which includes: a) policies and procedures reflecting an open and safe system which addresses safety, children's rights and familial rights, b) procedures for selecting, screening, training, and supervising staff to decrease the risk of sexually abusive behavior, c) staff guidelines for interventions with residents, d) safety education for residents, e) protocols ensuring environmental safety, f) procedueres addressing allegations or disclosures of sexual abuse, g) internal evaluations and external reviews.
2. A strong, structured behavior management program where management and control of behavior are maintained through program structure and staff/resident interactions.
3. A safe therapeutic environment and an effective therapeutic milieu.
4. Close staff supervision based on a high staff-resident ratio, and continuous monitoring by staff of all interactions. Video and audio monitors and sensors may also be in use in common areas, but do not replace staff presence.
5. A therapeutic milieu which includes a facility safe environment, secure space, a strong peer culture, and a program philosophy which is consistent throughout.
6. A structured, well-balanced program which provides modalities developed to impact adolescent problems, and which allows very little unstructured time.
7. Highly trained staff who have received specialized training in child sexual abuse issues, with emphasis on treatment of youthful victims and sexually abusive youth.

8. A multidisciplinary, multimodal design to impact on the treatment issues of both victims and sexually abusive youth.
9. A positive human sexuality program which emphasizes the development of positive attitudes about sexuality, healthy relationships, and safe sexual practices.
10. Ongoing, planned program evaluations. [6]

***Reintegration and Aftercare***

"The first day of your program is the day you are released." This statement was made to youths on the first day of treatment in a sex offender program at the Maine Youth Center in South Portland, Maine. The paradoxical nature of this statement underscores the fact that, unless offenders maintain the gains made in the institutional treatment setting when they are released into the community, the undergirding principle of public safety is denied. In discussing the reintegration of juvenile offenders into the community and referring to the concept of reintegrative confinement, Altschuler and Armstrong write:

> What kind of requirements are involved? In general terms, reintegrative confinement emphasizes:
>
> - Preparing confined offenders to reentry into the specific communities to which they will return.
> - Making the necessary arrangements and linkages with agencies and individuals in the community that relate to known risk and protective factors.
> - Ensuring the delivery of required services and supervision.
>
> To the extent that these general specifications are not met, there is little reason to expect that reoffending behavior will diminish or that the overall performance of youth returning to the community will improve. [7]

Planning for transition and reintegration into the community begins at the outset of a youth's confinement in an institution. Assessments at the front-end of institutionalization determine risk levels, treatment needs, and programming for the youth for the singular purpose of preventing the future occurrence of sexual assault. Interventions, throughout the institutional regimen of treatment, are designed to prepare each youth for reintegration into the community.

Altschuler and Armstrong"s Intensive Aftercare Program Model (IAP) identifies the following sets of program characteristics for the institutional and transition phases:

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[6] National Adolescent Perpetrator Network (1993). The Revised Report of the National Task Force on Juvenile Sex Offending, The Juvenile and Family Court Journal, 44 (4), (p.75).

[7] Altschuler, D., Armstrong, T., & Mackenzie, D.L. (1999). Reintegration, Supervised Release, and Intensive Aftercare, Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin, (p.2).

**Institutional Phase**

- Prerelease planning
- Involvement of outside agencies and individuals in institution
- Targeted community activities during confinement period

**Transition Phase**

- Testing and probing of reentry prior to placement in the community
- Structured stepdown process using residential placement or intensive Day treatment
- Provision of multimodal treatment services
- Discrete case management services
- Use of graduated sanctions and positive incentives
- Provision of supervision and surveillance beyond ordinary working hours
- Reduced caseload size / increased frequency of client contact
- Multistage decompression process.

As previously stated, relapse prevention is the most widely embraced model for sex offender treatment. One reason for its pre-eminence is that it not only provides a specialized treatment approach for sex offenders, but also addresses the external dimension of supervision and mangement. Throughout institutional treatment, relapse prevention identifies specific triggers, high-risk situations and precursors to sex offending that are unique to each offender. Oftentimes, these warning signs are subtle and difficult to discern. As offenders progress through treatment in the institution the triggers and precursors are well documented and provide supervisory agents with important information that maximizes the effectiveness of supervision the community. Furthermore, relapse prevention addresses the need for specialized supervisory practices and interagency collaboration when offenders are released into the community.

## III. Components and Elements of a Model Treatment Program in a Juvenile Correctional Facility

### *Program Design*

Sex offenders committed to juvenile correctional systems are a highly heterogeneous group, who present a wide array of treatment needs, risk factors, and behavioral issues. Given this population's high potential for aggressive, criminal, and sexually acting behavior, safety within the institution is of immediate and paramount importance. A comprehensive program to treat sex offenders in a correctional facility must address the need for a seamless delivery of services from custodial care to clinical program activities. Security / custody and treatment should be viewed as "two sides of the same coin". In a correctional treatment program security and treatment are mutually dependent upon one another. In fact, treatment enhances security, and the effective, consistent implementation of security procedures and daily living routines is a prerequisite to treatment. Daily correctional life is the laboratory in which new patterns of thinking and behavior are enacted.

Sex offender treatment is most effectively implemented using a cognitive-behavioral model that incorporates a progressive phase or level system to represent and structure advances in treatment. A cognitive-behavioral approach recognizes that the thinking of this minute may become the behavior of the next. Offenders are constantly engaged in thinking that may generate irresponsible, criminal, and / or aggressive behavior. If they are allowed to continue that thinking, without intervention or interruption, they are, indeed, practicing and rehearsing those selfsame thinking patterns targeted for correction. Daily living structure, appropriate and necessary security measures, and the treatment program, itself, become the key elements of an atmosphere, where staff (not the more antisocial and powerful youth) are in control, and all youth can experiment safely with new and responsible ways of thinking, behaving, and relating.

A core cognitive-behavioral treatment process is the centerpiece of a comprehensive program. As a central, consistent, connective locus of interventions, the core treatment process ensures the establishment and maintenance of those conditions which are necessary for the effective treatment of serious sex offenders, i.e., a prosocial, moral environment and atmospshere.

A major issue to be addressed in maintaining these necessary conditions refers to the criminogenic factors in the lives of these youth. It has become evident that programs designed to focus exclusively or predominantly on sex offending behaviors are of limited value. Sex offenders, who enter correctional systems, bring a host of issues to the treatment arena, sex offending being one of them. Many of these youth have been leading criminal lifestyles and sexuality is one arena in which they offend. Thus it is

important that a core treatment process targets the wide range of criminogenic factors that are part-and-parcel to the youths' lifestyles.

In correctional settings these youth use tactics to control and manipulate staff. They form a web of secrecy that maintains a criminal subculture. The most criminal youth maintain a high degree of control over the peer culture. In fact, treatment is sabotaged on overt and covert levels day in and day out. These criminogenic issues must be addressed if treatment is to be meaningful. A primary purpose of the core treatment process is to promote the replacement of antisocial values, beliefs and thought processes with prosocial views of life, while impacting and co-opting the criminal influences in the peer culture.

The program focuses on teaching youth the skills of responsible self-management and self-regulation. As they learn about the effects of their actions on other people, especially their victim(s), they develop the tools to report and correct thinking errors, and learn to identify and manage precursors to offending. They become so clearly aware of their subjective experience, i.e., thinking, feelings, perceptions, fantasies, that they cannot commit a criminal or sexually aggressive act, without making a fully deliberate and conscious choice. As they implement mental correctives (e.g., reasoning, responsible decision-making, moral inventories, pre-empting criminal thoughts, thought-stopping, redirection of thinking) they begin to look at themselves, other people and the world in new and different ways.

Two maxims of the treatment process refer to "the primacy of implementation" and "the discipline required in change." Treatment is not something that happens only in group and individual counseling. A youth who goes to group and effectively discusses anger management, then two hours later gets into a fight, is expanding and ingraining his repertoire of aggressive and criminal behavior. Treatment is of value only insofar as he exercises the discipline to implement the correctives he has learned in group. Following the rules of the institution and relating respectfully to staff and peers require the implementation of the same correctives that are essential to the youth's ongoing capacity to manage his criminal, aggressive and sexually assaultive thinking, fantasies, and behavior.

### *Major Objectives*

The following major objectives are identified in a model treatment program:

#### Denial and Minimization

Most sex offenders enter the juvenile correctional system denying, or seriously minimizing their antisocial and deviant behavior. They are quick to blame others for their actions and, oftentimes, perceive themselves as unjustly incapacitated. Denial and minimization are critical issues to be addressed in treatment;

however, they should not preclude a youth's participation in treatment. The program must address denial and minimization, utilizing strategies that introduce victim empathy and relapse prevention elements in the initial stages of treatment.

**Accountability**

Personal accountability is a cornerstone of effective treatment. Individual responsibility must be established. The primary focus of treatment interventions is on current behavior and thinking. There are no excuses for irresponsible, aggressive, and harmful behavior. At the same time, the program requires active participation, self-disclosure and the implementation of cognitive and behavioral correctives. Each youth must implement what he has learned. Change requires discipline, as each youth is held accountable for his behavior, thoughts, and fantasies.

**Victim Empathy**

One of the most important objectives is that each offender develop an accurate perception of the effects of his behavior on his victim(s). This work is a fundamental element in his work on denial, as he develops accountability for his thinking and behavior. The offender develops the capacity for an examination of conscience. The development of victim empathy permeates all aspect of the program, as the treatment regimen addresses the offender's capacity to victimize others, without regard for the consequences and effects of his behavior.

**Thinking Errors and Cognitive Distortions**

Antisocial patterns of thought (e.g., "I can do whatever I want whenever I want", "I have the right to take whatever I want", "Other people are not important and do not count"), and distorted perceptions of oneself and others (e.g., "Although she is 4 years old, she not only wants sex with me, she came onto me sexually", "She must do what I want, or she will be punished") are the pillars of sexual assault. As such, treatment must focus on dismantling and eliminating thinking errors and cognitive distortions, while replacing them with responsible and prosocial patterns of thought.

**Skills Deficits**

Treatment addresses identified skills deficits, teaching offenders assertiveness skills (when indicated), communications and interpersonal skills, daily living skills, anger management, stress management, and vocational skills. Skill building interventions equip offenders to live responsible lives in the

community. These new sets of skills support new and responsible ways of thinking, behaving, and relating to others.

**Relapse Prevention**

Relapse prevention teaches that there is no cure, management is forever. Offenders learn how to identify offense precursors, i.e., high-risk situations and emotional states (e.g., anger, anxiety, depression) that trigger vengeful thoughts and deviant fantasies, so that they can implement coping strategies to interrupt and eliminate those thoughts and fantasies. They learn to become immediately aware of warning signals, cues, and stressors in the environment and within their psychological functioning so they can pre-empt aggressive and sexual acting out.

***Program Components***

The core treatment process, as discussed in the section, *Program Design*, utilizes a set of program components to accomplish the major objectives. Key components are:

*Group Counseling*

Group counseling is the primary mode of treatment for sex offenders. Groups should be run by two staff. Ideally, male and female co-counselors lead sex offender groups. It is important that the groups are highly structured, with specific rules for behavior and peer interactions. Staff must control all aspects and contingencies of the group, ensuring that the more antisocial, aggressive youth do not dominate others. It is the obligation of staff to set the tone of group, maintaining decorum, respect, and purposefulness within the program's objectives and parameters.

The main purpose of group is to learn to identify and correct thinking errors and cognitive distortions. To do so, group work emphasizes the need for the honest reporting of behavior and the thinking that accompanies it. Groups explore behaviors and issues that have arisen in the unit and institution, and in the youths's lives (e.g., family issues, friendships, sexuality, relationships, plans for the future, etc.), describing the actual thoughts that occur during incidents, behaviors, and while considering the issues. In the course of probing discussions, staff teach correctives for the thinking errors and cognitive distortions by modeling new thinking skills, e.g., structured moral inventories, reasoning, responsible decision-making, etc. Group becomes a process in which youth are constantly reframing the way they think about their behavior, relationships, and issues in their lives.

Relapse prevention is also a focus of group work. Youth identify and describe the precursors to sexual offending, i.e., feelings of anger, depression, or anxiety, deviant sexual fantasies, passive planning for offending. Importantly, they learn to implement

coping strategies and interventions to interrupt and manage the sequence of precursors. They also describe high-risk situations that can trigger strong affective states and / or deviant sexual arousal, as well as identifying warning signals and cues that they may offend.

*Individual Counseling*

Individual counseling, in a correctional sex offender program, supports and expands the work being done in group. This modality allows staff to work more closely with youth on their unique problems and issues. Individual counseling encourages the development of rapport between the youth and counselor. Their relationship becomes a critical arena in which to promote the change process. At times, these sessions are tantamount to tutoring sessions, helping the youth to more effectively implement the mental correctives they learn in group, psychoeducational activities, and other areas of the program. Individual counseling is also important in tracking each youth's progress, or lack of progress through the treatment process. Treatment goals and objectives are routinely reviewed, and action plans are developed between the counselor and youth in the effort to achieve the goals and objectives.

*Journals*

Sex offenders maintain a daily written record of major examples of behavior and its concomitant thinking processes. The purpose of the recording of thinking and behavior is to help each youth develop the capacity for self-awareness and self-reflection. Oftentimes, programs utilize a journal format for this work. The journal can take any number of forms, e.g., thinking logs, reflection reports, diaries. The journal can be maintained throughout the day, or it can be a time-limited exercise on a daily basis, or a prescribed number of times per week.

Following are actual examples from an exercise entitled the Reflection Hour:

- "*Violent thinking* – I had violent thinking today towards a boy in school. I was walking down the hall and I felt like smacking him and pushing him. My muscles got all tensed up but I never went any further than that. I did not deal with this very much.

  *Criminal fantasies* – Today I had rape thoughts towards a certain staff member. It has gotten quite out of hand and now I have them whenever I see her. Some were a lot more violent than others. Some just a little, but all have some violence in them. I didn't deal with today's rape thoughts at all. I just left them."

- "I want to make my Reflection Hour totally about victims issues. I have decided to talk about some issues that are very hard. Sometimes I have to

open sexual acts and it is embarrassing and humiliating. This will be my first Reflection Hour in a bunch that will be about my victims.

There is one time when me and my sister were down behind the barn. I can't remember how we got there. I tricked her into letting me tie her down. When I was done tying her down I started undressing her. I planned to rape her. She started crying and begging me to let her go. Now I had her pants pulled down and I rubbed vaseline on her vagina. I was starting to get undressed. But seeing her cry took a lot of the excitement away and I changed my mind about what I was going to do. I talked to her and promised to let her go if she would jerk me off."

- "Well today I had some criminal fantasies towards my first period teacher and my second period teacher also. When I arrived in both of these classes I sat down and started examining them and then I began having some sexual and violent thoughts about them in my mind. At the beginning of these thoughts I only thought about having sex with them, and then all of a sudden some thoughts of raping them came into my mind also. I caught myself at about one minute or so into the fantasizing and I realized that it was wrong so I worked hard to redirect it. I redirected this thought by thinking about how they would actually feel if I committed these acts on them and the pain and terror that it would cause them deep within them. I thought that if I did these acts on them that I would get caught and sent to an adult prison for along time of my life. I would also leave my family in unbearabale pain and grief."

*Psychoeducational Activities*

Psychoeducation is an important adjunct to the core treatment process. This program component ensures that knowledge and information required to implement the program is presented in a structured, didactic manner. This formalized regimen of teaching prosocial beliefs, attitudes, and skills provides consistency and direction to the treatment process. Psychoeducation also ensures that the diverse, broad-ranging needs of sex offenders are addressed. The psychoeducational modules can be taught by clinical staff, line staff, and in some cases, youth who have mastered the information, have the skills to impart the information, and who have made significant progress in the treatment process. (It should be noted that staff must be present and closely supervise those infrequent situations where a youth may teach a module.)

Examples of psycheducational modules are given in the prior section on *Psychoeducation* (p. note the actual page this is on).

*Therapeutic Recreation and Leisure Activities*

Therapeutic recreation integrates program and treatment goals into recreational and leisure activities. Sports, games, and all forms of recreational activity are purposeful in that they reflect major programmatic goals and objectives, encouraging, teaching, and providing arenas to practice prosocial behaviors and relationships.

Every moment outside of treatment activities, education, vocational training, and daily routines and living practices are included in this component, underscoring the primacy of implementation. Structured recereational and leisure activities are facets of this component; however, youth are constantly guided in using their "free-time" constructively. Sex offenders, in treatment, compartmentalize their experiences. As stated before, a sex offender may effectively discuss anger management in group and get into a fight later in the day. He may help orient a new youth to the program, then later in the day talk about criminal activity with another peer. Wheresover responsible thinking and behavior are compartmentalized, treatment is fully compromised. Thus each youth's leisure time must be directed and monitored as he practices the implementation of correctives and coping skills.

### *Program Structure*

A therapeutic atmosphere is a key element in comprehensive treatment programming, emphasizing respectful and supportive relationships, while reinforcing responsible and prosocial behavior. A therapeutic atmosphere is a necessary condition for the implementation of the core treatment process throughout the program components. Fairness, consistency, and predictability are crucial features of the environment and culture of the treatment program. The following structural elements are essential constituents of sex offender programs in juvenile correctional facilities:

#### *Prosocial Peer Community*

One of the most serious difficulties facing treatment programs in juvenile correctional systems is the concentration of like-minded antisocial youths in the same setting. Antisocial youth are the most difficult to treat when they are housed together. However, this is a non-negotiable reality in juvenile corrections. Thus it is imperative that staff control all contingencies in the facilities and treatment arenas. A major factor, in the facilities, that profoundly impacts the ability to provide treatment is the nature of the peer community and the culture of that community. As an individual has a personality, framed and driven by certain beliefs, values, mores, and ways of thinking, so does a group or community of people have a culture which represents the shared beliefs, values, and mores that define that community. A community of antisocial youth is driven by power, force, and domination. Stronger peers exert predatory influences over the weaker peers. Criminal activity, antiauthoritarianism, and opposition to treatment are prevalant themes in the community's functioning.

A prosocial peer community is designed to co-opt the antisocial subculture, and as such, is a prerequisite to treatment in a juvenile correctional facility. Treatment teams and staff determine the beliefs and values of the culture, maintaining constant control over the peer community. Openness and honesty are mandated (understanding that specific methods are required to develop and maintain these attributes), procedures and practices are implemented that ensure that stronger peers cannot dominate the weaker, and respectful relationships are expected at all times.

The development and maintenance of a prosocial peer community requires a steadfast commitment from facility administration and leadership. It must be reflected in the philosophy of programming or treatment, codified in policy, and operationalized through standard procedures. Staff training ensure that every person working with the youths, no matter what their positions—custody, clinical, maintencance, food service, etc.—act in full accordance with the tenets and procedural elements of the prosocial peer culture.

*Behavior Management System*

A correctional sex offender program utilizes a behavior management system to describe, define and manage the behavior of youth. It includes rule setting, procedures for increasing responsible behavior, procedures for decreasing irresponsible and criminal behavior, and strategies for positive interpersonal relationships. The behavior management system is designed to create and maintain new and responsible behavior. It is important to note that responsible institutional behavior does not always indicate that a youth will maintain that behavior when he is released to the community, or that he will not recidivate.

In designing the treatment program, administrators and clinical staff must describe a theory of behavior management, i.e., an understanding of human psychological functioning, behavior modification, and learning principles. The implementation of this theoretical structure, through clear definitions of expected behaviors (rules), disciplinary procedures, positive reinforcement of responsible behavior, and negative reinforcement of irresponsible behavior is crucial in achieving rational, self-managed behavior. The behavior management system ensures that behavior in the institution is always being reinforced (positively or negatively) and modified.

Staff interaction strategies are key elements in behavior management in a correctional institution. The behavior management system must be described in detail in a procedure manual to guide staff in implementation. The procedures are for staff, equipping them with guidelines on how to perform the tasks that comprise the behavior management system. Staff training further equips them with the knowledge about human psychological functioning and learning theory that undergird the system. They learn to teach good behavior and to ensure that it is recognized and rewarded.

They learn to use negative reinforcers to decrease the frequency of unwanted behavior, understanding these interventions within the context of the treatment program, i.e., the negative reinforcers serve as "cognitive-behavioral brakes", interrupting irresponsible and criminal thinking and behavior.

*Level System*

The level system is a progressive stage model that utilizes a positive reinforcement method to reward responsible behavior, while representing each youth's advancement through the treatment program. Each progressive stage, or level, incorporates specified goals, activities, and duties that the youth must complete before moving on to the next level. Youth are evaluated in the functional domains of behavioral self-management, treatment participation, prosocial peer relationships, and respect for other people as they advance through the levels. Thus the level system integrates behavior management, discipline, and treatment progress. Each level represents a wide array of performance indicators that provide specific feedback to the youth. Each level also has corresponding increases in rewards that give the youth greater degrees of personal choice.

The level system provides predictability, improves objectivity in decision-making, and sets out well-defined parameters for tracking progress. Expectations are clear and youth know where they stand in the program. The level system is an important structural element in maintaining a therapeutic atmosphere that is safe, respectful, and supportive. It ensures consistency and fairness, while underscoring each youth's individuality, as he receives privileges and incentives based on his progress in treatment.

**Program Evaluation and Monitoring**

Program evaluations are conducted for two primary purposes: 1.) a process evaluation ensures that the necessary components for effective treatment are included in the program design, focusing on how programmatic operations are organized and implemented; 2.) an outcome evaluation determines whether the program interventions have been effective in bringing about desired changes in residents.

Righthand states, "Evaluations of sex offender programs are few and, when conducted, their designs frequently are inadequate (Camp and Thyer, 1993). Most outcome studies utilize recidivism rates to assess treatment effectiveness. Yet, low rates of recidivism, short follow-up periods, variability in outcome measures (e.g., arrests or convictions) and other methodological problems limit the usefulness of this approach."[8]

[8] Righthand, S., & Welch, C. (1999). Youths Who Have Sexually Offended: A Review of the Professional Literature, Unpublished manuscript, (p.64).

Long-term studies to determine the effectiveness of juvenile sex offender treatment do not exist.

As juvenile correctional systems plan sex offender programs, it is imperative that the capacity to conduct process evaluations is included in the initial phase of program planning and implementation. Program evaluation is, oftentimes, an afterthought in the planning process. Programs and treatment protocols are implemented, without an evaluation infrastructure in place. Thus data is not collected from the programs' inceptions, and it becomes difficult to determine whether the program is being implemented as designed, meeting the hetereogeneous needs of youth. Furthermore, the capacity to conduct outcome evaluations, with internal integrity, is compromised before the programs are implemented. Program evaluation should be a primary focus of the planning process from its earliest stages. Evaluation, in this sense, becomes a driving force for program development and implementation.

Przybylski and English write, "a program evaluation should not be a one-time event, although it is typically conceived of in this manner. Rather, evaluation is an ongoing process that should be part of a feedback loop which guides program development and operation."[9] Program evaluation is, in fact, a management tool and process. It ensures that a comprehensive system is in place to provide appropriate services to juvenile sex offenders, based on risk and need at different stages of treatment and movement through the system. The authors present a standard evaluation model, consisting of " four criteria that define an effectively managed program:

1. An acceptable description of program goals and objectives;
2. Sufficient and appropriate program activities in place to achieve the objectives;
3. Program performance information about each activity that signal whether and
   to what extent activities are being carried out and objectives are being met; and
4. A definition of acceptable performance." [10]

The following, more detailed and system-related criteria, are presented for utilization in evaluating and managing sex offender treatment practices throughout juvenile correctional systems:

1. A continuum of programs and services are available to meet the heterogeneous needs
   of juvenile sex offenders. A range of programming, from intensive residential to

[9] English, K., Pullen, S., & Jones, L. (Eds.) (1996). Managing Adult Sex Offenders: A Containment Approach. Lexington, KY: American Probation and Parole Association, (p.12.3).
[10] *Ibid.* (pp.12.5 - 12.6).

outpatient services matches the risk levels of youth to treatment needs and incorporates programming to deal with presenting co-morbid problems, i.e., developmental disabilities, substance abuse, and mental illness.

2. A mission statement and philosophy of treatment are clearly documented and
effectively communicated to all staff in such a way that all practices are guided by the mission statement and underlying philosophy.

3. A sex offender typology distinguishes the varying clinical and criminal character-
istics and dimensions of youth committed for sexual offenses throughout the correctional system.

4. Each youth undergoes a literature-driven sex offender specific assessment upon
entering the correctional system, including an assessment of risk, social attitudes and beliefs, sexual attitudes and interests, and general psychological functioning.

5. Differential classification procedures ensure that programmatic services meet the
individual and special needs of each youth.

6. A comprehensive treatment planning process ensures that an individualized treat-
ment plan is developed and written for each youth. This process includes systematic and periodic reviews to monitor, update and modify the treatment plans wherever indicated.

7. Major program goals and objectives are documented and are fully consonant with the
mission statement and philosophy of treatment.

8. Well-defined criteria are documented for the purpose of determining successful pro-
gram completion, program suspension, program re-entry, and program termination.

9. Program environments are appropriately structured to support and maintain healthy peer cultures in which youth can learn, grow, and practice new and responsible behaviors and relationships.

10. Correctional staff and treatment personnel are organized into functional units or
    teams that implement a seamless set of custodial, security, and treatment interventions to direct and monitor youths' daily living practices, behavior, relationships, and program involvement.
11. A behavioral management system is documented, implemented and understood by
    all staff and youth, ensuring that responsible behaviors and positive, respectful relationships are recognized and reinforced, while irresponsible behaviors are managed and corrected.

12. A schedule of daily activities includes all elements of required behavior, e.g., per-
    sonal hygiene, education, recreation, treatment. Time spent in each activity reflects the value of the activity in the philosophy of treatment.

13. Treatment components, therapeutic modalities, and programmatic activities and
    interventions are designed and implemented to support each youth in meeting the program's expectations and achieving the goals and objectives delineated in Individual Treatment Plans.

14. Transitional and aftercare programming and services are central components of sex
    offender treatment, insisting upon collaborative efforts between institutional personnel, probation and parole personnel, families, and community-based service providers. Such collaborative efforts begin when each youth enters the correctional system to enhance assessment, treatment planning, sex offender treatment, and community re-integration.

15. A comprehensive training plan is designed and implemented to ensure that all staff
    are equipped with the requisite knowledge and skills to manage and treat juvenile sex offenders. Training reflects the philosophy of treatment and includes all staff who work with the youth.

16. An offender tracking system maintains a database, compiling, at a minimum, demographic information, youth movement through the correctional system and sex offender programs, and projected release dates.

17. Program monitoring and quality assurance plans and procedures ensure that pre-
    scribed policies and practices are delivered as planned.

## An Optimal Continuum of Sex Offender Services in a Juvenile Correctional System

An optimal continuum of sex offender services in a juvenile correctional system (refer to illustration) incorporates a range of programs and services to meet the heterogeneous needs and varying risk levels of juvenile sex offenders. Each component of the continuum is designed to maximize public safety. The guiding principle of treatment is to reduce the risk that a sex offender will reoffend. Programs and services encourage and guide the development of internal changes in each offender's personality functioning, while delivering specialized risk management practices in the community to deter victimization.

The optimal continuum of services, in providing a coordinated range of programs, ensures that a consistent treatment philosophy and orientation inform each component of the system. The nature and intent of programming remains constant as youth progress along the continuum.

Upon entering the juvenile correctional system, every sex offender undergoes a comprehensive sex offender specific assessment. Effective assessment is the prerequisite to treatment and service delivery. The assessment assigns a risk level and delineates treatment needs. This information drives the decision-making process that determines program placement for each sex offender.

Institutional programs include:

- **Intensive Treatment Units** are located in medium and maximum security facilities. These programs are for high risk offenders and take 18 to 24 months to complete.

- **Residential Treatment Units** are located in minimum security facilities. These programs are for medium risk offenders, who do not present serious behavioral problems and have no history of escapes. These program take 9 to 12 months to complete.

- **Privatized Staff-Secure Residential Treatment Facilities** allow correctional systems to provide state-of-the-art programming to identified offenders. Collaboration between the correctional system and juvenile courts set the criteria for placement in these facilities. These facilities add depth to the continuum of sex offender services.

- **MR/DD Treatment Units** provide specialized approaches to sex offender treatment for youth with mental retardation and developmental disabilities, whenever these limitations prevent them from benefiting from other types of programs. These youth may also be vulnerable to abuse in a correctional system, requiring specialized housing and programming.

- **Prescriptive Programming** is tantamount to outpatient treatment within the correctional system. This programming is designed for low risk sex offenders, who do not require comprehensive treatment. Group counseling is the most commonly utilized modality for prescriptive programming. Oftentimes, a regimen of psychoeducational modules is utilized. Youth learn about the effects of victimization, thinking errors and cognitive distortions, and complete relapse prevention plans. Prescriptive programming takes 6 months to complete.

Intensive Treatment Units and Residential Treatment Units provide environments and specialized services to ensure the safety of youth and to meet specialized needs. Younger, immature youth are housed in separate units. Older, aggressive and antisocial youth are separated from the other populations. Specialized treatment is provided for youth with co-morbid substance abuse problems and mental disorders.

Collaboration and effective ongoing communication are key elements in an optimal continuum of sex offender services. In institutional programs, multidisciplinary teams deliver a seamless set of custodial and daily living practices, and treatment services. Understanding that the goal of treatment is to successfully reintegrate each offender into the community, interagency collaboration begins when the offender is in institutional programming and intensifies as he nears release. Interagency collaboration is a fundamental element of parole and community services in the effort to maximize public safety.

The Case Management and Review Process provides administrative oversight for each offender's movement through the correctional system and ensures that parole and aftercare planning effectively meets the risk level and needs of offenders being released into the community.

The range of parole and community-based services includes:

- **Stepdown Transition Facilities** provide structured residential settings that assist offenders in moving from highly structured institutional settings. Programmatic emphasis is placed on cognitive, affective, and behavioral management skills, as well as daily living skills development.

- **Group Homes** provide less structure than the stepdown facilities and do not provide a concentrated programmatic emphasis. In the most ideal of situations, offenders would move from the stepdown facilities into group homes.

- **Therapeutic Fostercare** increases the range of options on the continuum in moving offenders from institutions to leading crime-free lifestyles in the

community. Trained foster parents provide home environments for offenders, monitoring their involvement in school, employment, and peer circles. The home environments are structured to support the care and management of juvenile sex offenders, ensuring that no one resides in the home who could be a target for sexual offending.

- **Day Treatment Centers** provide highly structured and programmed settings for offenders living at home, in group homes, therapeutic fosterhomes or independent living placements. Educational and treatment services are provided.

- **Outpatient Services** ensure that treatment is maintained in the community, no matter what the placement or living arrangements for the offender. Importantly, treatment agents communicate consistently with parole agents and families to prevent the occurrence of a sex offense.

- **Pilot Programs** utilize innovative and cutting edge approaches to sex offender management and treatment. An important example of an innovative approach that shows promise is Multisystemic Therapy (MST). MST targets multiple domains and factors in the lives of juvenile offenders and utilizes intensive family and community-based treatment and interventions to promote behavior change.

It is important for administrators and clinicians to maintain an updated knowledge of the literature and research on sex offender treatment, adapting promising approaches and practices to their systems.

Risk management practices, implemented when offenders are released into the community, provide external services that decrease the opportunities and capacities for youth to reoffend. Intensive supervision and polygraph examinations are commonly utilized risk management practices.

Juvenile correctional systems are faced with the daunting task of treating increasing populations of juvenile sex offenders. These hetereogeneous populations present a variety of risk levels, needs and problems. It is clear that a “one size fits all” approach does not reflect the population served. Thus a continuum of programs and services is necessary in meeting the needs of these offenders. However, a comprehensive range of programs, in and of itself, is not sufficient in achieving the goal of maximizing public safety. An optimal continuum of services requires an undergirding philosophy and consistent guiding principles which ensure coherence in service delivery. Planning, collaboration, and communication are foundational elements in matching programs to risk levels and needs and to the transition and reintegration of offenders into the community.

## IV. Additional Resources

There are several resources available to assist juvenile facilities in the development of sex offender treatment programming. These resources include:

**For more information contact:**

David Berenson, Director of Sex Offender Services
Ohio Department of Rehabilitation and Corrections
1050 Freeway Drive, North
Columbus, OH 43229
(614) 728-1680; Fax: (614) 367-0745

Lee Underwood, Psy.D., Program Consultant
The GAINS Center for People with Co-occurring Disorders in the Justice System
Policy Research, Inc.
345 Delaware Avenue
Delmar, NY 12054
(800) 311-4246; Fax: (518) 439-7612
E-Mail: gains@prainc.com

Council of Juvenile Correctional Administrators
Stonehill College
16 Belmont Street
South Easton, MA 02375
(508) 238-0073; Fax (508) 238-0651
E-Mail: emailcjca@aol.com

### Websites

The following websites provide general information on juvenile sex offender treatment:

Council of Juvenile Correctional Administrators
http://www.corrections.com/cjca

Justice Information Center
http://www.ncjrs.org

The GAINS Center for People with Co-occurring Disorders in the Justice System
http://www.prainc.com/gains

Office of Juvenile Justice and Delinquency Prevention
http://www.ncjrs.org/ojjcorr.htm

U.S. Department of Justice, National Institute of Corrections
http://www.nicic.org

# APPENDIX A:

# OHIO DEPARTMENT OF YOUTH SERVICES

# JUVENILE SEX OFFENDER PROGRAMS

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## INTRODUCTION

In 1988, the Department of Youth Services (DYS) implemented Sex Offender programs at the Training Institute of Central Ohio (TICO) and the Riverview School for Boys (now the Riverview Juvenile Correctional Center). At that time there were one hundred and six (106) youth committed for sex offenses in the Department's institutions. The nature of the types of Sex Offenders committed to the Department's custody became a critical factor in creating many difficulties in the development and implementation of these Sex Offender programs. As a state correctional agency, the Department receives the most serious of Juvenile Sexual Offenders. In most cases, they manifest either antisocial personality features, violence, habitual/chronic patterns of sexual offending, or a combination of these three (3) features. A study of Sexual Offenders in DYS Institutions in August, 1993 documented that, despite committal charges, seventy-six (76%) percent of Sexual Offenders had been committed for acts of Rape and that the most frequent ages of victims ranged from four (4) to ten (10) years of age. Victims who were five (5) years old comprised the largest age group of this population. The National Task Force of Juvenile Sex Offending describes this population as "hard-core, antisocial." The consensus in this field is that this is a very difficult population to treat (Hare, 1993; Andrew, 1994; Pithers, 1989; Laws, 1990; Prentkey, 1990). The literature is further conclusive that the effective management and intervention with this population requires highly structured programming that is thoroughly consistent in practice and implementation and is driven by a cognitive-behavioral treatment protocol (Andrew and Bonta, 1994; Gendreau, 1994; Ross and Gendreau, 1990; Greenwood, 1992).

In 1989, the TICO Sex Offender program was moved to the Indian River School (IRS). In 1990, a Sex Offender unit was implemented at the Maumee Youth Center (MmYC). By 1994, the number of Sex Offenders in the institutions had increased to one hundred and sixty (160) Sex Offenders.

In 1992 and 1994, two (2) Task Forces were appointed to examine structural issues regarding the Department of Youth Services' Sex Offender programs and to make recommendations to improve the quality and utilization of these programs. Both Task Forces' primary structural recommendation was designed to ensure an integrated treatment approach to Sex Offenders, driven by one (1) philosophy of such programming. To that end, discussion focused on the advisability of placing all Sex Offenders in one (1) institution.

Also in 1994, Keith Kaufman, Ph. D., a researcher at Children's Hospital in Columbus, Ohio, initiated a joint, Federal grant-funded project with the Department of Youth Services to evaluate the Sex Offender programs offered by the Department. The first phase of the project involved utilizing the Quality Service through Partnership (QStP) process with the Department of Youth Services' Sex Offender staff to develop a psycho-educational treatment manual. This strategy was designed to meet the issues that had been identified by the two (2) working Task Forces.

By the Fall of 1995, it became evident that an integrated, cohesive approach to Sex Offender programming was imperative to improving the quality of Sex Offender services offered within the Department of Youth Services. It was at this time, that the decision was made to convert the Riverview Juvenile Correctional Center (RJCC) to an exclusive Sex Offender population. However, by 1999, the increasing number of juveniles committed to the Department of Youth Services for Sexual Offenses grew from one hundred and six (106) in 1988 to approximately three hundred and sixty (360) in 1999, thus demanding that the decision to provide offense specific programming to all adjudicated Sexual Offenders at Riverview Juvenile Correctional Center be reconsidered. In early 1999, the Department's recently built facility, Ohio River Valley (ORV), developed forty nine (49) beds for those youth who received Court commitments for Sexual Offenses from the Southern Ohio Counties. At the same time, the decision was made that those Sexual Offenders currently being housed at the Riverview Juvenile Correctional Center would transition to a larger facility, Scioto Juvenile Correctional Center. This transition was complete in December, 1999.

## CUSTOMER REQUIREMENTS

The Quality Service through Partnership Teams that were identified by the Department of Youth Services and the staff from Children Hospital identified the following customers for the project to develop a unified Psycho-educational treatment module for the Sexual Offender population:

- The citizenry and public of Ohio
- The Juvenile Courts
- The youth in Sex Offender programs
- The families of these youth
- The victims of the youth

This Task Force realized that, if it was to meet the requirements of the aforementioned customers, it would have to meet the immediate and specific requirements of the following internal customers:

- The Department's Executive staff
- The Sex Offender program staff
- The Department's parole staff.

It is important that the customer requirements for the Sex Offender program be realistic and practical. If we are going to meet the requirements of the first set of customers, we must, first and foremost, define the requirements of our internal customers. These are the requirements that must be met if the Sex Offender programming is going to work toward a vision of successfully programming for adjudicated Sexual Offenders, thereby making the communities of Ohio safer and more peaceful. The requirements of our internal customers are described as follows:

- A realistic Sex Offender treatment protocol has been developed, driven by an easily understood philosophy that serves as a coherent, consistent frame of reference and guide for all staff.
- A research validated design of differential placement units has been developed to ensure that youth are appropriately placed for the purposes of safety and treatment effectiveness.
- A literature based behavioral management system has been developed to provide for philosophically and procedurally consistent, coherent intervention with youth behavior that lies outside the institution's rules of conduct and behavioral guidelines of the Normative Peer Culture.
- A program of education services has been designed to meet the educational needs of all youth at SJCC, ensuring that age, developmental issues, and individual needs are addressed.
- A comprehensive, consistent, intensive, program and schedule of training has been developed and implemented to provide staff, at all levels, with the knowledge and skills necessary to the management and treatment of sexual offenders from ages 12 to 21.
- A plan has been developed to address staff and personnel issues that occur with Sex Offenders, ie., stress, potential burnout, intrapersonal issues and interpersonal problems.
- A comprehensive, seamless service delivery model has been developed to ensure that institutional programming is consistent and coordinated with parole and aftercare services, from the point of commitment to discharge. The institutional program has been designed, emphasizing that it is one (1) phase of a continuum of service delivery. The interdependence between institutional programming and aftercare has been built into a comprehensive model.

## PHILOSOPHY AND DESIGN CONCEPT

Effective correctional intervention and programming requires that a consistent program philosophy be known and applied diligently throughout the organization. Sex Offender programs must operate, therefore, in the belief that you will do better in a highly structure, predictable environment that is morally principled and holds them accountable for their behavior, while guaranteeing that they are treated with complete respect.

Furthermore, Sex Offender programs must operate in the belief that each offender is of equal value to all other people, and that he must be made aware of the consequences of his pattern of offending for his own life and future. Ultimately, he must deal with the fundamental life choices and develop the skills necessary to maintain responsible choices over time and across situations.

The antidote to the volatility of this population is the consistent, cohesive, purposeful implementation of contemporary correction practices. This practice must be understood as fundamental to treatment, not as separate from it. Corrections and treatment are the same thing. Effective treatment enhances security. Effective security is a prerequisite to treatment. The external system of supervision and management has been referred to as "cognitive-behavioral brakes," stopping the offender from committing openly criminal and irresponsible behaviors. If the offender is allowed to act out, he reinforces and ingrains existing patterns of behavior, those same patterns that programming is designed to help change. In this way, he is more apt to learn new behaviors and, at least, try them out. Offenders must learn and rehearse responsible behaviors, not irresponsible ones.

Relapse Prevention has an external dimension of supervision built into the model. Understanding that offenders deal with conflicting sets of desires and will not necessarily make responsible choices, the institutional structure is highly evolved and staff target internal and external situations which are high risk situations for offenders. These are the situations that lead to anger, violent thinking, thinking about crime, deviant sexual fantasies and the desire to dominate others. By intervening in this way, behavioral problems are minimized, thus the "cognitive-behavioral brake."

Relapse Prevention focuses on the fact that institutional programming is only preparatory for release. Youth are constantly learning about themselves, victims, and intervention skills so that hey can return to the communities equipped to manage their behavior and treatment of others. Given this model, the institutional phase must work hand-in-hand with aftercare to create networks of collateral resources and contacts (families, schools, community treatment providers and agencies, and the Parole Officer) to supervise offenders and to communicate in such a way that intervention happens before an offense is committed.

In working to provide effective Sex Offender programming and planning for aftercare at the SJCC, the design of a multifaceted program is based upon the following:

- Constructive involvement between staff and youth is a central ingredient for bringing about change.

- Youth must, at all times, be constructively involved in purposeful activity. Daily activity schedules (seven [7] days per week from wake up to bedtime) are critical elements of effective programming. Activity schedules must reflect the important components of the program; Group Therapy, Education schedules, recreational activities, etc.

- Normative Peer Culture and its group process is the centerpiece of the treatment technology. Treatment content and approaches must be organized around the framework of Normative Peer Culture.

- Successful programming for Sex Offenders involves re-education and re-socialization, as offenders eliminate thinking errors, replacing them with new ways of thinking that are activated in new responsible behaviors.

- Structure, accountability and effective, consistent behavioral management through a rule system, a merit and level system, and diligent staff supervision is essential in working with this group of youth as they are oftentimes highly resistant, defensive and manipulative.

- Effective programs ensure a seamless correctional treatment to aftercare services continuum.

## UNIT PLACEMENT

### BOONE UNIT (SEX OFFENDER MENTAL HEALTH):

This unit has been identified to serve those youth committed to the Department of Youth Services for committing sexual offenses who also require more intensive mental health intervention than that provided in the general population.

The youth on this unit range in age from twelve (12) to twenty-one (21)and have been committed for various sexual offenses. The maximum capacity of this unit is thirty (30) youth. The youth who are placed on Boone Unit have been determined to have mental health issues which are severe enough in nature to impair their ability to function on a larger non-mental health unit. Those youth identified remain on this unit until they acquire the skills and ability to function and benefit from treatment on a non-mental health unit. The youth selected for this cottage require increased staff direction and supervision, along with individualized behavioral management plans.

The Boone Unit staff are committed to reducing the stigma associated with mental illness. They will also provide mental health education and Sexual Offender programming and will remain focused on problem identification and awareness necessary for youth stabilization.

Youth will be admitted to Boone Unit after being assessed by the Psychology staff to determine if the youth meets one or more of the following Mental Health Unit criteria:

- Displays behaviors related to clinical disorders that are so severe as to limit the youth's ability to function safely on a non-specific unit. Some appropriate considerations: Extreme social withdrawal, increased agitation for two (2) weeks or more, or depressive symptoms lasting two (2) weeks or more which are unrelated to current trauma and are a change from the youth's usual functioning.

- Displays low intellectual functioning which interferes with youth's ability to interact appropriately with peers and staff. Examples: Cannot learn and retain simple social norms (waiting in line, taking turns, etc.), has difficulty understanding boundaries between youth and staff, does not understand how to communicate needs.

- Displays residual substance abuse issues which mirror or produce dissociative states. Youth reports visual images, smells, or tastes. Emotionally unstable, goes from controlled behavior to uncontrolled sustained behavior. Flashpoint temper, cries easily, complains of racing thoughts. History of intense drug usage with significant usage of hallucinogenic substances.

- Displays Post Traumatic Stress Disorder related symptoms which includes severe anxiety reaction, sleep difficulties (less than three [3] hours confirmed sleep) or closely reoccurring flashbacks with dissociative features.

- Displays loosening of thought process/inability to link concepts together in a logical manner. Youth cannot form complex thought. Extreme concrete thinking, e.g., Youth cannot link a discussion on returning a lost wallet to making decisions on what is right and wrong to choosing not to hurt others for their own benefit.

- Displays reoccurring patterns of behavior and thinking which currently restricts appropriate social relationships and the inability to process treatment materials. The consistent inability to pick up on social and respond with the appropriate behavior. Youth does not understand the appropriate way to interact. Note, youth who are knowledgeable about appropriate behavior but choose not to act appropriately are not appropriate.

- Displays a pattern of deep cutting (emergency treatment, stitches, etc.) or self injury (broken nose, broken facial bones, amputation of digits, etc.) for sexual or psychological pleasure. Superficial cutting is probably not appropriate for consideration. Attention seeking and manipulative self injury may not meet the criteria.

- Displays problems with reality testing outside of issues related to the current offense, ie., youth does not understand simple concepts such as right and wrong, cannot distinquish between fantasy and reality.

- Displays probable fetal alcohol syndrome with related problems. Behaviors most likely will not be responsive to medications. Behaviors may include: impulsive behavior, hyperactivity, inability to retain learning, lack of concentration, and the inability to delay gratification.

In accordance with the Department of Youth Service's Directive, all new admissions to Scioto Juvenile Correctional Center (SJCC) are to be interviewed by the Psychology staff within seventy-two (72) hours of their admission. Youth who meet any one (1) of the above mentioned criteria are referred to the Psychology staff assigned to Boone Unit for further evaluation and a recommendation. The decision of the Psychology staff will then be forwarded to the Institutional Parole Officer to arrange the transfer of this youth to Boone Unit.

Youth who are placed on one (1) of the general population units at SJCC and are later identified as candidates for the Mental Health unit will be referred in writing for an evaluation by the Psychology Department. The request for evaluation should include behavioral observations, verbalizations from the youth, any relevant background information and staff's impression why the youth needs placement on the Mental Health unit. The Psychology staff assigned to Boone Unit will evaluate the youth and forward written recommendations to the referral source. If the youth meets admission criteria and can benefit by the transfer then the transfer protocol will be implemented. Youth evidencing ongoing problems with suicidal issues may be a priority placement on the unit.

The primary focus of Boone Unit is to reintegrate those youth who have demonstrated a positive adjustment while on the Mental Health unit into the general population at SJCC. When the treatment team feels that a youth has adjusted positively, they will conduct a staffing to determine the degree of such progress. If it is determined that a youth can be successfully reintegrated into the general population then current institutional policy and procedure will be followed.

**WOODSON UNIT (NON-SEXUAL OFFENDER, ACUTE MENTAL HEALTH UNIT):**

This unit has been identified to serve those youth committed to the Department of Youth Services for various crimes who require very intensive mental health intervention.

The youth on this unit are generally sixteen (16) years of age and above and demonstrate severe psychiatric difficulties. These difficulties result in behavioral or mental status symptomology requiring a higher level of structure, supervision and interaction than is present in the general population or on the Mental Health units addressing the chronic mental health needs of youth in the Department of Youth Services' institutions. These difficulties oftentimes result in severe self-injurious behaviors, suicidal gesturing, or other atypical behaviors that are difficult to manage, e.g., psychosis, mania, etc. Those youth who possess a clear Axis I and/or Axis II Mental Health diagnosis would be transferred to Woodson Unit from any Department of Youth Services' institution.

The program on Woodson Unit will assist youth by utilizing the following:

- Individualized Treatment Plans

- Specialized Behavior Management Programs

- One-on-One Counseling

- Structured Group Therapies

**BUCKEYE (PRE-RELEASE):**

The Pre-Release Unit (Buckeye) will house youth who have met the required criteria for release to the community or the Community Based Options Program (CBOP). Those youth, who are within ninety (90) days of their Presumed Release Dates or have been approved for release by the Release Authority. These youth may be enrolled in school, GED studies or graduates. These youth can be eligible for supervised work details. Those youth deemed Pre-Release will be expected to act as role models to all new youth entering the institution.

- All youth will be at SJCC for the time period specified by their Judge unless granted a Judicial Release (prior to the youth's midpoint in his Minimum Sentence) or an Early Release (granted after the midpoint of their Minimum Sentence but prior to the expiration of the Minimum Sentence). Following the Minimum Expiration Date, the Department of Youth Services can keep youth longer depending upon behavior, participation in the prescribed programming and victim concerns.

The remaining five (5) units will house those youth committed to the Department of Youth Services for the commission of various sexual offenders. Following the completion of the Sexual Offender Assessment Tool (SOAT) at Circleville Youth Center (the Department's Reception Center), all youth will receive a level of dangerousness score. Unit assignments to the remaining units will be made utilizing this information as well as the age of the offenders.

## UNIFIED CASE PLANNING:

Each youth at Scioto Juvenile Correctional Center shall have a Unified Case Plan (UCP). This plan will contain all of the assessments and planning components necessary to develop individual programming goals and objectives. This plan will outline the needed services, supports, education programs, etc., which have been identified through assessments and staffings that take place at the Reception Center (Circleville Youth Center). The Unified Case Plan will be completed in accordance with the timelines identified in Directive X-14.

The documentation of needed services, supports, and educational programs of the Unified Case Plan will include the following:

- Achievable Goals
- Measurable Objectives for Each Goal
- Action Steps and the Responsible Persons
- Youth Strengths and Weaknesses

## PSYCHO-EDUCATIONAL COMPONENTS

One of the primary focuses of the Scioto Juvenile Correctional Center Program is to ensure that youth's behaviors, thinking patterns and ways of relating to other people in their daily experiences are explored honestly and belief systems, values, and methods of coping are examined. This program is not relegated to only groups, journals, and curricula; rather it is the minute by minute, behavior by behavior experience of youth throughout each day of their programming at SJCC. The targets for change are thinking and behavior. Psycho-education is important only insofar as it promotes cognitive behavioral change.

The goal of this program is to help each offender stop offending. The goal is not to "teach" about the thinking errors, relapse prevention, and victim awareness, but to lead offenders to internalize responsible thinking, ways to prevent relapse, and to understand victimology as a barrier to future offending. The psycho-educational components include nine (9) components , each with specific goals, objectives and knowledge. However, the primacy of implementation of the knowledge and correctives learned in these components is the fundamental motivation for all treatment efforts.

Normative Peer Culture, the treatment components, activity schedules, and the behavior management system are uniquely integrated into a comprehensive system of supervision and programming that consistently holds offenders accountable to act, think and relate in new and responsible ways. Every element, feature, and method designed for the program is meant to serve the primacy of implementation, teaching the youth the discipline required in change.

- Sex Offender Group Therapy

  Sexual offending characteristics are most effectively addressed in the Group Therapy process. The combination of confrontation and support are most useful in this process. As a strong culture develops, youth are encouraged to report their daily experiences and provide information about themselves. The Social Worker's primary function is to identify patterns of the cycle from these reports with the goal of demonstrating how the member's daily accounts relate to it.

  As the group members begin to understand and define the elements of treatment, the members begin to take on the role of identifying offending patterns in their peers, and finally begin to see similar patterns in themselves.

  The offense-specific group process dictates the direction of individual programming and is dependent upon confrontation and accountability. In order to motivate change, the youth must be placed in a position where he has to change and begin to feel uncomfortable with his offense behaviors before he can achieve self-control. The therapeutic relationship is necessarily different than most counseling situations. These differences must be acknowledged by both the youth and the Social Worker in order for change to occur.

  Victim advocacy is the primary focus of this program. The National Task Force on Juvenile Sexual Offending stated in its 1988 report: "Protection of the community…is the highest priority of intervention in sexual offending. The community is the ultimate client." "Community safety takes precedence over any other consideration, and ultimately, is in the best interests of the offender." These assumptions require the Social Worker to consider the needs and rights of others. The Social Worker's demonstration of concerns for victim protection and community safety parallels the goals of programming and is congruent with the treatment process.

  Again, the National Task Force Report (1988) states: "Confidentiality cannot apply in the treatment of this population because it promotes the secrecy which supports offending." The message to all youth in the Sex Offender specific group must be to give up the secrecy that supports their problem and they must be accountable for controlling their behaviors.

  The group process frequently involves the confrontation of peers. The thinking errors that allow sexual offending must be confronted and beliefs that support risk must be challenged. Confrontation is the tool that guides the youth's process of change. The goal of confrontation is to provide feedback to help the youth be aware of the nature of their thoughts and behaviors. When confrontation is based in anger and shame, and expressed through yelling, name-calling, and put-downs, it may be a powerful experience that influences the youth's thinking; but the change may be one that increases defensiveness and self-protection rather than understanding. Confrontation should be a calm and rational process, a direct and purposeful progression toward an identified goal.

  Gathering early developmental history is an area that can often be explored during assessment or the early sessions and may facilitate the engagement of youth in the treatment process. The youth needs to record a written or taped biography that reveals his personal perception of what his life experience has been. The biography helps clarify an understanding of the individual's view of the world and his place in it. Biographical information also provides milestones, and the onset of a youth's progression to sexual offending.

  Meaningful participation in the offense specific group process and the demonstration of understanding the change process is enhanced by a variety of more structured, educational components. Because the needs and deficits of each individual will vary, the following treatment components can be enhanced by "homework assignments" for workbooks such as "Pathways," "Who Am I and Why Am I in Treatment," "Breaking the Cycle," "Relapse Prevention," etc. However, these workbooks or "homework assignments" must not be substituted for the Sex Offender specific group therapy process.

- Victim Empathy

  The Victim Empathy component will be taught on each unit at Scioto Juvenile Correctional Center. This component focuses on the following goals and objectives:

Goal 1: Learn to accurately identify and appropriately respond to other people's feelings and behaviors.

Objective A: To learn and understand what victim empathy is. What role does it play in human relationships? What purpose does it serve?

Objective B: To learn what appropriate feelings are and how their expression is influenced by social norms.

Objective C: To learn and practice how to identify other people's feelings.

Objective D: To learn how to communicate with respect, while identifying and clarifying feelings.

Goal 2: Understand how what one has done to harm others affects and effects them, particularly in relation to victims of abuse.

Objective A: To develop a very real awareness of the affects of their offenses on victims.

Objective B: To identify different types and instances of harm done to victims; short and long term.

Objective C: To learn to put one's self in the place of the victim.

Goal 3: Understand who the indirect or secondary victims of sexual offending are, ie., families of victims, one's own family, friends, the community, and how they are affected.

Objective A: To learn what victimization is for indirect victims.

Objective B: To learn to put one's self in the place of these people.

Goal 4: Demonstrate the ability to consistently engage in empathetic ways of relating to others in daily living.

Objective A: To learn to do the Moral Inventory as a portion of the Process of Deterrence.

Objective B: To identify ways to use empathy in relationships on a daily basis.

Objective C: To practice new ways to use empathy in relationships.

- Social Skills

This treatment component is essential to change for those youth who demonstrate a deficit is this area. This component can be taught on any treatment unit after appropriate documentation from staff.

Goal 1: Learn and incorporate new pro-social communication skills.

Objective A: To learn and improve personal hygiene.

Objective B: To maintain cleanliness and neatness is daily living environment.

Objective C: To develop the ability to structure and schedule responsible daily living.

Objective D: To learn living skills for the future, ie., personal finances, methods to find and interview for employment, housekeeping, finding housing, insurance, etc.

Objective E: To learn effective problem solving skills.

Goal 2: Develop responsible and effective social skills.

Objective A: To identify misleading messages, myths, and misunderstandings about relationships (cultural, interpersonal, family).

Objective B: To learn and understand about the different kinds of human relationships people have.

Objective C: To develop a repertoire of responsible behaviors to improve relationships with others.

Goal 3: Understand and learn to appropriately express one's emotions and their responses.

Objective A: To identify one's own life experiences that have created one's unique understanding and ways of expressing emotions.

Objective B: To develop new perceptions of one's own emotions and the affects of other people on one's own emotion.

Objective C: To learn and practice ways to deal with emotions and express them, without victimizing others.

- Thinking Errors

This treatment component shall also be taught on all treatment units. This component is also crucial to the change process.

Goal 1: Understanding what thinking errors are and how they relate to daily functioning, patterns of abusive behavior, the Negative Behavior Cycle and the Relapse process.

Objective A: To learn what the thinking errors are and how they work in one's personality.

Objective B: To demonstrate an understanding of the central role thinking errors play in criminal behavior by connecting thinking to feelings and behaving.

Objective C: To learn what correctives or mental deterrents (Process of Deterrence) are and how they work to disrupt and redirect negative thinking.

Goal 2: Develop and demonstrate the ability to identify and correct thinking errors in one's own self and in the Peer Culture.

Objective A: To help other peers in group identify their own thinking errors.

Objective B: To learn to accept intervention from others to stop and replace thinking errors, and to learn to appropriately intervene with other peers regarding their thinking errors in daily functioning.

Objective C: To develop and continually improve the ability to activate mental correctives, leading to responsible behavior.

- Negative Behavior Cycle

This treatment component encourages youth to recognize how their use of thinking errors and irresponsible decision-making influences their daily functioning, which oftentimes ends is sexual offending.

Goal 1: Understand what the Negative Behavior Cycle is and how it relates to the youth's daily functioning and abusive behavior patterns.

Objective A: To learn and understand the model of the Negative Behavior Cycle.

Objective B: To learn and understand the role and the importance of the Negative Behavior Cycle in sexual offending.

Objective C: To understand how the Negative Behavior Cycle steps work.

Objective D: To identify and understand one's personal Negative Behavior Cycle (including the precursors in daily living).

Goal 2: Demonstrate ability to identify cycle behaviors in self and others and develop interventions to disrupt the cycle.

Objective A: To demonstrate the ability to identify cycle behaviors in others.

Objective B: To identify cycle behaviors in self, while on the treatment unit.

- Sex Education

This treatment component is designed to challenge the myths held by most youth versus the reality of positive, healthy, sexual relationships.

Goal 1: Learn and understand the human body and sexual functioning.

Objective A: To learn the anatomical and physiological human sexual functions and processes.

Objective B: To learn about and understand myths, misconceptions and misunderstandings about human sexual development and functions.

Goal 2: Understand positive and healthy human sexuality.

Objective A: To learn about society's myths and taboos regarding sexuality.

Objective B: To identify and describe the features and elements of positive human sexuality.

Objective C: To clarify values about sex by examining how one learned about it, who did the teaching, role of pornography, etc.

Objective D: To learn about the societal and legal definitions of acceptable and unacceptable criminal forms of sexual behavior.

Objective E: To clarify one's understanding of sexual fantasy and masturbation in one's sexual life.

Goal 3: Understand the contemporary role of sexual responsibility in the context of diseases and pregnancy.

Objective A: To go over the Reception Center's special topic on Sexually Transmitted Disease and examine the consequences more in depth.

Objective B: To learn about the "Big Picture issues" regarding sexuality, in terms of responsibility and choice.

Objective C: To examine the issues regarding teen pregnancy, teaching birth control and learning about responsible fatherhood.

Objective D: To come to an understanding and self-knowledge about the importance of responsible sexuality.

Objective E: To understand the benefits and rewards of positive human sexuality.

- Anger Management

This component must be completed by all youth who demonstrate problems controlling their anger or those youth determined to have used anger as a motivation in the commission of their sexual offense.

Goal 1: Describe and understand one's own anger pattern.

Objective A: To utilize the Negative Behavior Cycle and Thinking Errors models to understand how one's own anger pattern works.

Objective B: To learn to intervene in the Negative Behavior Cycle and Thinking Errors process to manage and control anger.

Goal 2: Understand how one's own personal anger pattern relates to one's pattern of abusive behavior.

Objective A: To demonstrate the ability to disrupt one's own anger pattern and replace the anger with socially appropriate ways of relating to others.

- Own Victimization

This component is designed to help those youth who themselves were victimized to address their own victimization issues. The youth who complete this component will also be able to relate their own offense patterns to those abuses that they suffered.

Goal 1: Understand the impact of victimization.

Objective A: To learn about the role of denial and why sexual abuse is so difficult to be open about; explanation of the myth and misunderstanding common to people who have been abused as children.

Objective B: To learn about the range of feelings one must deal with in reaction to child sexual abuse.

Objective C: To learn to identify common thought processes associated with victimization.

Objective D: To learn about common behavior reactions and the development of patterns of abuse.

Objective E: To learn about the impact of sexual abuse on one's own self-image and feelings of power and control.

Goal 2: Through counseling procedures, help identified youth (by virtue of assessment and staff involvement) acknowledge their own victimization.

Objective A: To work with the youth to fully disclose his own victimization.

Objective B: To develop supportive relationships between treatment agents and youth to deal with the issues.

Objective C: To start the process of understanding the impact of victimization in terms of self-image, guilt, fear, emotions, thinking and behaving.

Goal 3: Understand and begin the process of healing.

This is a therapeutic process. Not every youth will undergo it. Levels of aggression, length of stay, reasonable progress in treatment, level of responsibility, and mental status will all serve as

factors in determining who will undergo this treatment. The institution's Psychology staff will be instrumental in the development of these Individualized Treatment Plans.

- Relapse Prevention

This treatment component will be ongoing throughout the youth's stay at Scioto Juvenile Correctional Center.

Goal 1: Learn and understand the Relapse Prevention model.

Objective A: To become able to describe the Relapse Prevention model and to accurately define the terms.

Objective B: To become able to present the model's components in a step fashion that reinforces the understanding of the Negative Behavior Cycle.

Objective C: To develop an understanding about how the components work together, in order to learn how to disrupt and deter inappropriate, deviant, and criminal behavior.

Objective D: To develop an understanding of the importance of Relapse Prevention in one's own life.

Goal 2: Learn to utilize material from life histories, as well as knowledge and information regarding personality functioning and patterns of offending, to apply Relapse Prevention to one's own behavior and treatment process.

Objective A: To identify the Relapse Prevention components in one's own behaviors.

Objective B: To be able to describe one's own Negative Behavior Cycle as it relates to sex offending behavior.

Objective C: To learn to identify non-sex offense specific behaviors that are a part of the relapse process.

Objective D: To learn to identify "escape and avoidance" alternatives.

Objective E: To learn to identify external and internal deterrents to disrupt the relapse process.

Objective F: To identify and document one's own support system in the community.

Objective G: To develop a realistic Relapse Prevention Plan that is agreed upon by the youth, staff, parole officer, and the caregivers in the community.

Goal 3: Implement and maintain one's own Relapse Prevention Plan in the institution and then in the community.

Objective A: To demonstrate the ability to recognize precursors to offending and irresponsible behavior, as well as one's own high-risk situations.

Objective B: To demonstrate the ability to implement escape and avoidance alternatives.

Objective C: To initiate and maintain communication with people in the external support system.

Objective D: To demonstrate the ability to consistently implement external and internal deterrents, as evidenced by increasingly responsible behavior.

- Individualized Therapy

Each youth will be assigned a Social Worker who will meet with the youth at least once bi-monthly for individual therapy. A part of this individual therapy will include ongoing assessment of the

treatment progress based on the treatment goals and objective specifically designed to meet the needs of the individual youth. Some specific issues dealt with in individual therapy include:

1) Sexually Deviant Arousal
2) Cognitive Behavioral Interventions
3) Thinking Errors Interventions
4) Value Based Interventions

- Recreation Therapy

Recreation Therapy is designed to improve performance in social, cognitive, motor, pyschological, and sensory integrative functioning through the use of various creative methods. Recreation therapy seeks to encourage learning by doing, both within the unit and through activities off the unit. The goals of Recreation therapy are as follows:

1) Develop trust in themselves and others
2) Gain competence in their abilities to accomplish tasks
3) Learn to control the symptoms that brought them to treatment
4) Learn values such as good manners, cleanliness, good language, work, and the need to achieve
5) Gain cognitive control in areas of concentration, attention span, memory and problem solving
6) Develop a greater awareness of self through physical activities
7) Learn the importance of the group

- Family Services

Every youth enters treatment with a "family," whether absent, distant, functional or dysfunctional, family issues must be addressed and the potential for family involvement must be assessed. The family system must be maintained if at all possible. This allows the Social Worker to help the youth come to terms with what the family means in each youth's life.

The Family Treatment model may involve the biological family, the adoptive family, foster or group home parents, the caseworker, the absent family, or the non-existent family. It can mean working with families to prepare a youth for independence or to re-integrate into the family. Families may be supportive or non-supportive, caring or reflecting the absent family or the nor-existent one. They can enhance the treatment process or sabotage it.

It can also mean separating from the family of origin and dealing with issues such as grief and loss. It sometimes means teaching the youth how to function as part of a family wherever he finds himself. Having positive relationships in a wide variety of settings is part of this process.

The Social Worker's and Parole Officer's plan for programming must take all of the above into account. Every youth who enters programming must work with what he is given in terms of family or the absence of family.

The goals of Family treatment are:

1) To provide support for the Juvenile Sexual Offender to continue the treatment process
2) Identification and interruption of the family patterns that allowed or supported the sexual abuse
3) To improve family relationships and maximize family strengths
4) To provide the information needed for the family's participation in Relapse Prevention

Family involvement and participation will be encouraged whether the youth is to return home after incarceration or not.

- Educational Services

The educational needs of youth at Scioto Juvenile Correctional Center will range from sixth grade through high school. Treatment issues identified in each youth's Unified Case Plan will be incorporated into each youth's

educational plan. Treatment staff will be invited to participate in the development of each youth's education plan.

Educational progress and progress on treatment issues being worked on in school will be communicated to the treatment team members through the Treatment Progress Reports and the Task Progress Reports. Teachers will conduct weekly meetings to get input from all of the youth's teachers prior to the completion of the Treatment Progress Reports.

Scioto Juvenile Correctional Center will implement an innovative approach to service delivery through a method known as "Inclusion or Team Teaching" in which one (1) or more regular teacher/s is teamed with a special education teacher, forming departments by subject matter. Each department will be given a large classroom and a smaller one. This model is intended to empower teachers to have more control and responsibility in determining the educational services to be provided to youth through collaboration. This new approach will help Scioto Juvenile Correctional Center accommodate federal rulings surrounding "least restrictive environment" issues for special education students, while providing an immediate solution to the shortage of classroom space, due to the increased number of special education students. The following factors are to be understood regarding the team teaching approach:

1) It is not mandatory for all teachers
2) Participating teachers will spend a minimum of one (1) year with the approach
3) Services will be evaluated every six (6) months
4) Training will be provided on collaboration, team building, and other needed topics
5) Co-teachers will determine class assignments within the department
6) Students with disabilities may still be mainstreamed in other teacher's classes
7) A co-teaching combined class size will not exceed twenty (20) students, ie., twelve (12) basic education and eight (8) special education students.
8) Planning periods for each teacher in a department will be scheduled at the same time to facilitate networking and collaboration.

Educational programs will continue to focus on a life skills approach, defined as the skills necessary for an individual to be a functioning and contributing member of society. The individual life skills programs will depend upon each youth's age, academic ability, and the post school activities each youth intends to pursue. Departmentalization and co-teaching will allow teachers to better identify and address student needs as part of the basic academic program. All basic requirements for graduation must be fulfilled.

In addition to basic educational programs, the following vocational programs are included in the educational service:

1) Personal Development-Focuses on the life skills necessary to establish and maintain a household, such as home safety, meal preparation, care of clothing, parenting skills, and the development of self-esteem and a sense of accomplishment.
2) The World of Themes-Teaches food preparation and other food service skills needed for employment in the food service industry. This program serves approximately twenty-four (24) students.
3) Occupational Work Adjustment (OWA)-Helps youth develop problem solving, communications, human relations, and other basic employment skills. Approximately sixteen (16) students between the ages of fourteen (14) and fifteen (15) are served.
4) Vocational Office Technology-Prepares youth to enter careers in the field of office management.

The Educational Services Department at Scioto Juvenile Correctional Center realizes that the changing nature of the population may make it necessary to add vocational programs.

Physical Education, Health, and Art are electives offered at the Scioto Juvenile Correctional Center.

Approximately sixteen (16) or eight percent (8%) of the Scioto Juvenile Correctional Center will be eligible for post secondary programming. All post secondary programming should take place after school hours, due to the shortage of classroom space.

## BEHAVIOR MANAGEMENT SYSTEM

On a daily basis, each youth's progress will be evaluated by Scioto Juvenile Correctional Center staff. Each youth has the opportunity to maintain the points given automatically at the beginning of each day. A youth's behavior throughout the day will determine how many points are detracted from his sum total for a given period of the day. Depending on the total points maintained in a given time period a youth may earn privileges and rewards and receive promotion to a higher level. This is called the Youth Behavior Management Program or the Level System. The model is based on the assumption that each youth begins each day with a set number of points. His behavior throughout the day will determine whether he loses or holds onto those points or even adds bonus points to his daily total.

Each day youths have the ability to earn a total of sixty (60) points. The day is split up into twelve (12) sections ranging in point totals from four (4) to eight (8) points per session. During these time periods, youth will start out with a total of sixty (60) points. Points can be subtracted for any reasons listed on the point detractor list. If the youths display any of the behaviors listed, points will be subtracted for the selected time period, by supervisory staff, (staff directly supervising the youth at the time period the behavior is displayed).

Each six (6) week evaluation period, the youths will begin earning points to reach that particular level. The point attainment scale is from 0 to 2520 points. This will allow youths to reach level, and still have accountability for a range of behavior within each level attained, ie., a youth could be a Level Two (2) with zero (0) points. He will have to reach 2520 points before he could be evaluated for Level Three (3) status. Once reaching Level Three (3) status, the youth will begin as a Level Three (3) with zero (0) points. If a youth's entire level is taken for serious rule infractions, he will begin the lower Level, always at zero (0).

| | | |
|---|---|---|
| Level 0 | - | 0 points to 2520 |
| Level One (1) | - | 0 points to 2520 |
| Level Two (2) | - | 0 points to 2520 |
| Level Three (3) | - | 0 points to 2520 |
| Level Four (4) | - | 0 points to 2520 |

There are thirty-four (34) behaviors and identified thinking errors that could cause a youth to lose points during the evaluation period:

1) Getting out of assigned seat/area without permission (Power Thrust)
2) Being late to class/activity without permission (Refusal to Accept Obligations)
3) Horseplaying * (Impulsive)
4) Refusing to follow staff directions ** (Power Thrust)
5) Any destruction of state property (your own, staff, peers or institutional property)** Or PDR (Power Thrust or Impulsive)
6) Coming to any activity/class, without necessary materials (Refusal to Accept Obligation)
7) Not taking responsibility for your own actions or mistakes * (Refusal to Accept Obligation or Victim Stance)
8) Being rude of disrespectful to staff * (Power Thrust or Lack of Empathy)
9) Agitating or annoying others (Lack of Empathy)
10) Disturbing others during and activity (Lack of Empathy)
11) Stealing or having contraband in your possession ** Or PDR (Impulsive or Lack of Empathy)
12) Intimidation of others (to include threats or gestures) ** ((Power Thrust)
13) Talking or noise making without permission * (Impulsive)
14) Any derogatory language, swearing or obscene or sexual language ** Or PDR (Power Thrust)
15) Any gang related activity (talking, writing, recruiting, gestures, etc) ** (Power Thrust)
16) Being excluded from Group therapy * (Refusal to Accept Obligations)
17) Arguing with Staff (Power Thrust)
18) Failure to complete treatment assignments * Or PDR (Failure to Accept Obligations)
19) Non-Completion of homework assignments (School or components) * (Failure to Accept Obligations)
20) Fighting (including shoving or pushing others) ** (Power Thrust)

21) Non-Participation in Group therapy ** (Failure to Accept Obligation)
22) Making sexual comments to others * (Impulsive)
23) Writing or drawing sexually explicit material ** Or PDR (Impulsive)
24) Staring or leering at peers or staff * or PDR (Impulsive)
25) Being placed in Time-Out * (Power Thrust or Failure to Accept Obligation)
26) Being placed on Cooling-Off ** (Power Thrust or Failure to Accept Obligation)
27) Being placed on Room Confinement ** Or PDR (Power Thrust or Failure to Accept Obligation)
28) Being placed in Isolation ** Or PDR (Power Thrust of Failure to Accept Obligation)
29) Any tatooing of self of others ** Or PDR (Victim Stance or Lack of Empathy)
30) Any self injurious behaviors ** Or PDR (Victim Stance or Lack of Empathy)
31) Poor Personal hygiene (Lack of Empathy or Victim Stance)
32) Group leaking * (Lack of Empathy or Refusal to Accept Obligations)
33) Victimizing peers or staff ** Or PDR (Lack of Empathy)
34) Any sexual touching or acting out physically ** Or PDR (Impulsive or Power Thrust)

*====Minimum of four (4) points must be taken
**===Minimum of eight (8) points must be taken
PDR=This is a "Special Point Detraction" request. This indicates that the behavior has earned more than a four (4) or eight (8) reduction in points. Therefore, the treatment team will need to decide the total points to be detracted based on the details of the specific behaviors. A staff member may request a "Special Point Detraction" by filling out the required form prior to weekly team meetings. The team will take into consideration the seriousness of the infraction and any mitigating or extenuating circumstances, such as compilation of like behaviors. The decision will be made at team and the points will then be deducted from the youth's daily total resulting in a weekly total for the youth.

All other behavior detractions listed are up to the discretion of the supervising staff at the time the behavior is exhibited. Deduction totals cannot exceed four (4) points for "structured" timeframes or eight (8) points for "unstructured" timeframes.

Each day is divided into twelve (12) sections. Eight (8) sections are during the school hours, or "structured" parts of the day and a youth could maintain up to four (4) points during these timeframes. There are three (3) timeframes which a youth can maintain eight (8) points each. These are less structured times, before breakfast, during lunch and after school. A youth has the ability to maintain sixty (60) points per day, if none are taken for negative behavior, he could earn four hundred and twenty (420) points for a weekly total. At the end of each evaluation period, (six (6) weeks each period), a youth has the opportunity based on the points he has maintained, to earn certain privileges or rewards. As the level promotion rises, the more attractive the privileges become.

During each six (6) week evaluation period, a youth has the ability to maintain seventy-five percent (75%) to one hundred percent (100%) of his points in order to earn a level move. Any points earned at the fifty percent (50%) or below level does not result in a level move:

| | | | | |
|---|---|---|---|---|
| ❑ | Total of 2520 | = 100% points earned | = | level earned |
| ❑ | Total of 1890 to 2519 | = 75% points earned | = | level earned |
| ❑ | Total of 1260 to 1889 | = 50% points earned | = | no level earned |
| ❑ | Total of 630 to 1259 | = 25% points earned | = | no level earned |

The total number of points that are available per week are four hundred and twenty (420), (if a youth does not lose any points for behaviors exhibited). If a youth earns at least three hundred and fifteen (315) points per week for a total of one thousand eight hundred and ninety (1890) during a six (6) week period of time , he still has maintained seventy-five percent (75%) of the total points available, thus he is still allowed a level move. Earning two hundred and ten (210) points per week or less ( or one thousand two hundred and sixty (1260) during the six (6) week period), would result in a fifty percent (50%) or less earnings.

Each six (6) week increment of points earned will result in a letter added to the level status. For example, the first six (6) weeks levels will be 1, 2, 3, and 4. The second six (6) week evaluation period, levels will be 1a, 2a, 3a, and 4a. The third week evaluation period, levels 1b, 2b, 3b, and 4b, and so on.

❑ Expectations/Rewards/Restrictions for Level 0 Orientation Level

Upon admission to the Scioto Juvenile Correctional Center, each youth begins at level 0 or Orientation Level. While on Level 0 or Orientation, each youth is expected to learn.

1) Institutional behavior expectations and rules
2) Overview of the Sex Offender Treatment components
3) Goals and expectations of each component
4) Language and clarification regarding youth's commitment to DYS to include length of stay, deferment process and review by the Release Authority
5) Learn the rules of Youth Conduct for group, school, cottage, cafeteria and all other areas
6) Learn the Youth Movement process
7) Learn and understand the Youth Grievance process
8) Overview of the Youth Disciplinary Hearing process
9) Participate in all treatment activities, based on individual limits and capabilities
10) No sexual contact with others
11) Exhibit no gang activity, association, etc
12) Maintain good basic hygiene

While on Level 0, Orientation status, each youth will undergo necessary medical examinations, school testing for purposes of school placement and he will receive appropriate state issued clothing (determined by the current season).

The following privileges can be earned while on Level 0:

1) Two (2) monitored phone calls to approved recipients per week
2) 9:00 p.m. Bedtime
3) Visitation Opportunities with parent/guardian once per month (once parent/guardian has attended orientation)
4) Availability of two (2) stamped envelopes for correspondence to approved recipients.

The following restrictions apply to Level O:

1) Only personal hygiene items may be ordered from commissary
2) No opportunity for extra outside activities (only those related to scheduled unit activities)
3) No special projects working with staff or Social Worker
4) TV restriction (set by treatment team)

- Expectations/Rewards/Restrictions for Level One (1)

A youth can receive promotion to Level One (1) status by the treatment team, by exhibiting consistent application of the expectations listed below. These expectations are goals for the youths to strive to achieve and should exemplify the youth's behavior the majority or the time. If the youth experiences difficulties during the evaluation period, he should exhibit the ability to refocus and to regain control of the situation without escalation to the point of a Time-Out of Room Confinement situation. It is expected that a Level One (1) youth be actually engaged in treatment and educational activities in a positive and progressive manner.

The following are expected behaviors of youth of Level One (1):

1) Actively participate in all group and school activities based on individual limitations and or capabilities
2) Youth should have presented a detailed life story, approved by their Social Worker
3) Participate in appropriate daily journal writing
4) No Category One (1) violations
5) Not currently on a Special Behavior Management Plan
6) No more than four (4) send-ups from the school area per month
7) No gang activity or association, etc.
8) No sexual contact, activity, or acting out
9) Completion of all treatment program requirements and assignments given
10) Completion of an Offense Cycle, approved by the Social Worker

11) Earn a minimum of three hundred and fifteen (315) points on a weekly evaluation score.

The following privileges can be earned while on Level One (1):

1) Two (2) monitored phone calls to approved recipients per week
2) Visitation opportunities twice per month with approved visitors
3) Availability of one (1) extra privilege chosen by youth from approved list of privileges (Approval of treatment team)
4) Availability of two (2) stamped envelopes for correspondence to approved recipients
5) 9:30 p.m. Bedtime
6) One personal hygiene product (in addition to state issue)
7) One commissary item (not to exceed $10.00)

The following restrictions apply to youth on Level One (1):

1) No opportunity for outside activities except those on scheduled unit activities

- Expectations/Rewards/Restrictions for youth on Level Two (2)

A youth reaching Level Two (2) status, has completed the Anger Management component and has shown a compassion and empathy for his victim(s). A youth on Level Two (2) status has maintained a Level One (1) status for a minimum of two (2) months consistently. A youth promoted to Level Two (2) status, should also exhibit:

1) Continued empathy for his victims (no objectification of victims)
2) Ability to utilize anger management tools learned in treatment
3) Continued ability to help peers without victimization
4) No victimization of others, peers, or staff
5) Active, positive participation in group, treatment, and school activities
6) No more than three (3) send-ups from the school area per month
7) No Youth Disciplinary Hearings
8) No Special Behavior Management Plans
9) No sexual contact with anyone
10) No gang activity, association, etc.
11) Earn a minimum of three hundred and fifteen (315) points on a weekly basis.

The following are privileges that can be earned on Level Two (2):

1) Allowance of personalized hygiene products
2) 10:00 p.m. Bedtime
3) Four (4) monitored phone calls weekly to approved recipients
4) Visitation opportunities twice a month with approved visitors
5) Extra hour of free-time on the weekends
6) Availability of extra privileges (2) from approved privilege list (approved by the treatment team)
7) Commissary order up to $15.00
8) Opportunity for a “Late Night” to include staying up late (after 9:30 p.m. until 11:00 p.m.), popcorn, pop, candy, etc., movies or music

- Expectations/Reward/Restrictions for youth on Level Three (3) status

Youth reaching Level Three (3) status are seen as role models for newer youths or youth’s experiencing difficulty in the population. These youth should exhibit consistency in their behavior. They should also initiate treatment opportunities, not waiting on their Social Worker to hand assignments to them. These youths should have ability to monitor their work individually and assist other peers with their work. Youths considered for Level Three (3) status should have maintained a Level Two (2) status consistently for at least two (2) months. These youth should also exhibit the following:

1) Active, positive participation in all group and/or school activities

2) Victim Empathy in discussing their offenses, also a victim letter should be written and submitted to the Social Worker and the Office of Victim Services (not mailed unless requested by the Office of Victim Services)
3) Completion of anger management and ability to utilize the tools learned on a regular basis
4) Initial work on a Relapse Prevention Plan
5) Exhibit continual peers assistance in group, school and on the unit
6) Completion of at least three (3) Treatment components
7) No gang activity, association, etc.
8) No sexual contact with anyone
9) No Category One (1) violations
10) No Special Behavior Management Plans
11) No more that one (1) send-up from the school area per month
12) Completion of family reunification or family issues plan. This may include a family staffing.
13) Earn a minimum of three hundred and seventy (370) points on a weekly basis.

The following privileges can be earned by youth on a Level Three (3) status:

1) Youth may use approved personalized hygiene products
2) 10:30 p.m. Bedtime
3) Five monitored phone calls to approved recipients
4) Visitation opportunities twice per month with approved visitors
5) Availability of three (3) "Late Nights" per week
6) Availability of two (2) extra privileges selected from the approved list (approved by the treatment team)
7) Availability of five (5) stamped envelopes per week for correspondence to approved recipients
8) Ability to order lunch from the snack shop (World of Themes), once per week
9) Availability to work in the school area, ie., landscaping or on special projects such as community service off-grounds, with approved supervision
10) Commissary Order up to $20.00
11) Availability to work on the OWE program or as an aide to the teachers
12) Two (2) extra hours of free-time on the weekends.

- Expectations/Rewards/Restrictions for youth on Level Four (4) status

Youth reaching Level Four (4) status are the model citizens of the institution. This population should be comprised mostly of our youths on the Pre-Release unit. These are youths who have completely or nearly completed the Sex Offender Treatment program successfully and who consistently exhibit positive behavior in all areas, ie., school, cottage life and treatment. Youths reaching Level Four (4) status have completed a Relapse Prevention Plan and show they are consistently refining this plan and utilizing the tools identified in this plan to successfully complete each day without going into their "cycle." The following expectations must also be met in order to continue their Level Four (4) status:

1) Maintain active, positive participation in all areas, school, treatment and cottage life
2) No Special Behavior Management Plans
3) No more than one (1) write-up per month
4) No send-ups from school
5) No write-ups in the last three (3) months
6) No room confinements, isolations or restraint within the last three (3) months
7) No suicide observations or watch within the last two (2) months.

The following are privileges that can be earned by youth who have reached their Level Four (4) status:

1) Youth may order $25.00 or more from commissary
2) 11:00 p.m. Bedtime
3) Opportunity for six (6) monitored phone calls to approved recipients
4) Visitation opportunities three (3) times a month with approved visitors
5) Three (3) extra hours of free-time on the weekends
6) Availability of three (3) extra privileges from the approved privilege list (approved by the treatment team)

7) Opportunity for free “Visitation Photo” during visitation
8) Availability of six (6) stamped envelopes for correspondence to approved recipients.

# APPENDIX B:

# VIRGINIA DEPARTMENT OF JUVENILE JUSTICE

# SEX OFFENDER SERVICES

# PROCEDURE MANUAL

## SEX OFFENDER SERVICES AT JUVENILE CORRECTIONAL CENTERS

Developed by the Treatment of Adolescent Sex Offenders Committee (TASOC), Treatment Sub-Committee.

| | |
|---|---|
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| Presented to TASOC | January 1997 |
| Approved by TASOC | February 1998 |

TASOC Treatment Sub-Committee Members:

| | |
|---|---|
| Edward Wieckowski, M.A.<br>Psychologist Senior<br>Hanover Juvenile Correctional Center | Sub-Committee Chair |
| Els Deininger, M.A.<br>Psychologist Senior<br>Oak Ridge Juvenile Correctional Center | Sub-Committee Member |
| Marianne Garten, M.S.<br>Psychologist Senior<br>Bon Air Juvenile Correctional Center | Sub-Committee Member |
| George Perkins<br>Institutional Manager<br>Beaumont Juvenile Correctional Center | Sub-Committee Member |
| Gregory Smith<br>Acting Institutional Director<br>Hanover Juvenile Correctional Center | Sub-Committee Member |
| Stephen Strunk, Ph.D.<br>Psychologist Senior<br>Beaumont Juvenile Correctional Center | Sub-Committee Member |
| Dennis Waite, Ph.D.<br>BSU Chief Psychologist<br>Department of Juvenile Justice | Sub-Committee Member |

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# INTRODUCTION

The safety of the citizens of the Commonwealth demands juvenile sex offenders receive intensive treatment specific to their offenses during the period of their commitment to the Department of Juvenile Justice (DJJ). The Department offers residential services at the juvenile correctional centers (JCC) for the assessment and treatment of sex offenders to reduce their probability of reoffending once released into the community. This manual was developed to ensure juvenile correctional centers provide services consistent with the national standard of care for sex offender treatment. It provides general procedure guidelines for all JCC sex offender programs, with specific procedures determined at the facility level.

# OVERVIEW

The Department of Juvenile Justice (DJJ) began offering sex offender services in January 1990, at Hanover Juvenile Correctional Center (HJCC). The Ellen Allen self-contained-unit at HJCC was the first state-operated sex offender program for juvenile sex offenders. It was established to meet the treatment needs of the growing population of juvenile sex offenders within DJJ and to offset the high cost of private residential sex offender treatment. Since it opened, it served as a model for five additional sex offender self-contained units; three at Beaumont JCC, one at Oak Ridge JCC, another one at HJCC, and one prescriptive sex offender program at Bon Air JCC. The goals of these programs are:

1. **To provide individualized treatment specific to the needs of the sex offender;**

2. **To provide a normalization and socialization experience to improve social and adaptive behaviors;**

3. **To facilitate the sex offender's return to society and conformity to societal standards;**

4. **To reduce re-offending through a continuum of services and team effort between residential and community parole services.**

# IDENTIFICATION AND CLASSIFICATION OF SEX OFFENDERS AT RDC

Juveniles committed to DJJ and convicted of sex offenses are identified, evaluated and classified according to treatment needs at the Reception and Diagnostic Center (RDC). This information is documented in the juvenile's transfer file and arrives at the JCC with the juvenile. This process is outlined below.

## IDENTIFICATION OF SEX OFFENDERS AT RDC

Juveniles are evaluated and monitored extensively at RDC in Bon Air, VA. They undergo psychological, medical and social evaluations, and behavioral monitoring. Those who have a history of exhibiting deviant sexual behaviors are identified. The staffing team at RDC determines the JCC to which they will be transferred, determines their length of stay at the facility if it has not been assigned by the courts, and classifies their sex offender treatment needs.

## CLASSIFICATION OF TREATMENT NEEDS

A juvenile's treatment needs are classified at RDC as either mandatory, recommended or ancillary using an Assets and Service Recommendations sheet. A juvenile with a history of sex offending behavior would receive one of these classifications for sex offender treatment.

A mandatory classifications requires the juvenile to remain incarcerated until he completes his treatment, but not more than 36 months or past 21 years of age. This classification overrides his length of stay. Most juveniles who are committed to DJJ on a sex offense are classified as mandatory for sex offender treatment. Exceptions to this are juveniles with a "determinate" length of stay. The committing judge determines their length of stay and release date.

A recommended classification encourages the juvenile to participate in treatment but the juvenile cannot be incarcerated past his late release date.

An ancillary classification encourages the juvenile to participate in treatment but has no impact on his length of stay.

# TREATMENT AT THE JCCs

## REFERRAL OF SEX OFFENDERS AT THE JUVENILE CORRECTIONAL CENTER

When a juvenile arrives at a JCC, his file is reviewed by the intake staffing team, and he is assigned a counselor. The staffing team and counselor review his file and the Assets and Service Recommendation sheet that was completed at RDC. If the juvenile needs sex offender treatment, he is referred to the Behavioral Services Unit (BSU) for a sex offender assessment. The BSU therapist assesses the juvenile, and discusses the results of the assessment with the sex offender treatment team. Together, they decide the level of sex offender services the juvenile will receive at the JCC. This process is outlined below.

## ASSESSMENT PROCESS

A BSU sex offender therapist meets with the juvenile and performs a Sex Offender Evaluation using the Risk Assessment Interviewing Protocol for Adolescent Sex Offenders (Loss & Ross, 1988). The evaluation determines risk of re-offending, amenability to treatment, and appropriateness for the self-contained-unit.

## SEX OFFENDER SPECIFIC TESTS

The battery of tests an evaluator uses depends on the information needed and the intellectual capacity of the juvenile being tested. The Treatment of Adolescent Sexual Offenders Research Sub-Committee (TASORS, 1992) recommended the instruments below be used in assessing sex offenders whose intellectual functioning is in the low-average range and above. The MMPI-A or MMPI-2, and the MSI are mandatory for sex offenders entering the self-contained units.

Wechsler Intelligence Scale for Children-III (WISC-III) or Wechsler Adult Intelligence Scale-Revised (WAIS-III).

Mental Status Examination (MSE).

Risk Assessment Interviewing Protocol for Adolescent Sex Offenders (Ross and Loss, 1988).

Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) or Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2). Standardized, well researched methods of assessing an individual's personality make-up, as well as determining if deceit was involved in test responses.

The Multiphasic Sex Inventory (MSI). A method of assessing an individual's comprehensive sexual functioning, including sexually deviant behaviors, thoughts and fantasies.

The Mathtech Sexual Knowledge Questionnaire. A method of assessing an individual's knowledge of issues concerning sex, birth control, puberty, etc.

The Adolescent Cognition Scale. A method of assessing an individual's proclivity to distort his thought processes in order to reduce responsibility for his offenses.

*The Adolescent Sexual Fantasy Scale (ASFS). A method ofassessing an individual's arousal level to a variety of sexually deviant and non-deviant scenes.

*The Hare Psychopathy Scale.

*Screening Test for the Luria-Nebraska Neuropsychological Battery.

*J & J I-330 Bio-feedback Equipment.

* = Used on a pilot basis

Other tests may be administered for additional information to aid in assessment and treatment planning.

**CRITERIA FOR LEVEL OF SERVICES**

To meet criteria for placement in a DJJ self-contained-unit (TASOC, 1992) the juvenile must meet at least three of the following:

1) Sexual assault with threat or force, or sadistic sexual acts in which the psychological or physical suffering or humiliation of the victim is the key feature of the offense;

2) A pattern of sexually deviant behavior involving physical contact to one or more victims over an extended period of time;

3) Escalation and progression of sexually deviant behavior that involved physical contact (e.g., sequence of deviant fantasy, voyeurism, or frottage to sexual battery or rape);

4) Apprehended more than once for sex offenses;

5) Sex offenses against both males and females;

6) Sex offenses against strangers.

Additional criteria for self-contained units at Hanover and Beaumont Juvenile Correctional Centers:

- male

- 12-15 years of age at time of referral (Hanover)
- 15 or older (Beaumont)

- committing sex offense(s) involving physical contact with the victim (e.g., rape, sodomy,

sexual battery, etc.)

- full scale intelligence of 80 or above
- not psychotic
- compliant\non-aggressive behavior for at least 30 consecutive days prior to entering the program
- minimal denial (one month probation if necessary)
- "mandatory" sex offender treatment need

**TREATMENT TEAM RECOMMENDATIONS**

Within 30 days of the juvenile's arrival at a JCC, the sex offender treatment team meets to review the case. The BSU therapist reviews the results of the Sex Offender Evaluation, and other treatment team members provide additional information on the juvenile. After careful review, the treatment team identifies and documents specific sex offender services that would be appropriate for the juvenile. They determine whether he meets criteria for (1) the self-contained-unit, (2) prescriptive services, (3) is not amenable to treatment, or (4) does not need sex offender treatment.

**TREATMENT WAITING LIST**

Due to the large number of sex offenders in the Department, waiting lists may exist for sex offender treatment. Juveniles will be placed on the list in the order they arrive at the JCC. However, treatment staff may place a juvenile on a different position on the waiting list if it is considered clinically advantageous. For example, a juvenile who has a short length of stay and has a serious sex offense may need to begin treatment prior to a juvenile who will remain at the center for at least 18 months.

Juveniles placed on the waiting list for a self-contained unit will be given the opportunity to participate in prescriptive services. If they meet their treatment goals in prescriptive services, they may be removed from the self-contained waiting list at the discretion of the sex offender treatment team.

**TERMINATION FROM TREATMENT**

Each facility will have established guidelines, approved by TASOC, for youth who are terminated. The guidelines will determine how a youth may re-earn treatment privileges.

**JUVENILES NON-AMENABLE TO TREATMENT**

Juveniles may be "not amenable" to sex offender treatment if they refuse treatment, are non-compliant, do not admit any deviant sexual behaviors, and juveniles who began treatment but were terminated. These juveniles will be checked once per month by BSU staff to monitor amenability to treatment. Once they become amenable, they may be eligible to begin treatment. Juveniles who refuse treatment are asked to sign a Treatment Refusal Form, which documents their refusal. However, they can receive general therapy services during that time that would

focus on non-sex offender issues.

## JUVENILE CORRECTIONAL CENTER SEX OFFENDER SERVICES

Juvenile correctional centers offer a range of treatment modalities that include individual and group psychotherapy, psycho-educational groups and family psychotherapy, and post treatment sessions. These services are provided on an individualized basis in either of two tracts: self-contained units or prescriptive services. Self-contained units are residential treatment units where only sex offenders are housed. These units are reserved for the more serious offenders. Prescriptive services are offered to sex offenders in the general population, either those juveniles that don't meet criteria for the self-contained-units or those who are on a waiting list to enter the units. Juveniles in both tracts are offered the same treatment modalities, which are listed below:

Individual psychotherapy. One-to-one therapy by a BSU staff therapist to address specific treatment needs of the juvenile sex offender.

Group psychotherapy. Three or more juveniles meet regularly with a BSU staff in group sessions with the specific purpose of processing underlying dynamics of sex offenses and implementing a plan of prevention.

Psycho-educational groups. Structured groups of three or more sex offenders and facility and/or BSU or DCE staff who meet regularly to complete lesson plans of content material specific to sex offenses.

Family therapy. A BSU staff meets with the sex offender and his/her family to improve family relationships and explore and correct factors that contributed to the juvenile's sex offenses.

Post treatment. These sessions are designed for juveniles who have successfully completed their required sex offender services at the JCCs. They build on previous services and focus on issues such as relapse prevention, application of learned material and integration into the community.

### SELF-CONTAINED UNIT

Self-contained units provide intensive milieu treatment to male juvenile sex offenders. They are staffed by a psychologist senior, clinical social worker, institutional counselor, and cottage staff. Treatment staff are supervised by a licensed clinical psychologist. The institution superintendent, institution manager, and program managers provide administrative support for the programs. The major treatment modality is group process, both didactic and therapeutic. A typical week for juveniles in the units consists of two group psychotherapy sessions, three psycho-educational groups, a community meeting, one individual psychotherapy session, one counseling session, and monthly treatment team meetings. Family therapy is provided to juveniles by the clinical social worker or psychologist senior by appointment. Treatment is a team approach by

multi-disciplinary mental health professionals and cottage staff. Staff at all levels are actively involved in providing treatment services. Cottage staff may help lead psychoeducational groups and also reinforce in everyday cottage life what is addressed in treatment sessions. This milieu approach helps the juvenile apply what he learned treatment to the daily routine in the cottage and at the facility. This creates a society in miniature, one of appropriate socialization and normalization of behaviors.

**Treatment Objectives**

Juveniles at Hanover and Beaumont JCCs must complete at least 15 treatment objectives to successfully complete the program. They generally work on one objective at a time in the order they appear. Credit for an objective is given by the therapist(s) and juveniles in a group psychotherapy session. Once they attain credit for an objective they are responsible for demonstrating it for the remainder of their stay. The 15 treatment objectives are:

Autobiography: to examine his own life story

Disclosure of offense(s): to identify and report sexual offense(s) and deviant sexual behaviors

Cycle of offending: to identify, analyze, and chart the specifics of his offense cycle

Cognitive distortions: to become aware of, monitor and change his thinking errors related to sex offense(s) and everyday life

Log book: to maintain a daily record of feelings, thoughts, fantasies, and cognitive distortions

Feelings (power/anger/rage): to examine the role of affect and emotional management and control related to sex offense(s)

Defense mechanisms: to examine the role of defense mechanisms related to sex offense(s)

Role model: to exhibit pro-social interactions with staff and peers, and learn to improve decision making skills

Victim empathy: to examine the effect of his offense(s) on his victim(s) and his victim's family

Personal victimization: to process his own sexual victimization

Family issues: to identify and study family problem areas that contributed directly or indirectly to his offense(s)

Fantasy and arousal: to examine the role of these as related to sex offense(s) and reduce deviant sexual urges by using techniques such as thought stopping and covert sensitization.

Two personal treatment objectives: are based on the specific needs of each juvenile.

Relapse prevention: to integrate and apply treatment objectives and information from group psychotherapy and psycho-educational groups to interrupt his offense cycle and reduce the probability of re-offending; relapse prevention workbooks and/or videotapes may be utilized to help youth address this objective

Low functioning sex offenders at Oak Ridge JCC complete all of the above objectives except Logbook. They address the objectives at a more rudimentary level because they do not have the intellectual capacity to complete and understand the objectives to the same degree as juveniles at Hanover and Beaumont JCCs.

**Psychoeducational Curriculum**

At Hanover and Beaumont JCCs, the psycho-educational curriculum is based on the Psychoeducational Curriculum for Adolescent Sex Offenders (Richardson, Loss, and Ross, 1988), which covers four topic areas:

Topic 1: An Introduction to Sexual Aggression

Topic 2: Psychology of the Offender

Topic 3: The Victim

Topic 4: Human Sexuality

In addition to the above curriculum, the psycho-educational groups in the self-contained units at HJCC and BJJ address additional areas based on the needs of the juveniles in the program. These include: Emotions, Sexuality, Sexual Aggression, Treatment Issues, Interpersonal Relations, and Independent Living. The youth may be referred to other specialty treatment programs at the facility such as substance abuse, anger management, etc., if applicable.

Oak Ridge JCC uses the LifeFacts curriculum. This curriculum is highly structured and relies on visual materials to teach low functioning sex offenders about seven main areas of sexuality. These are outlined below:

1. Human growth and development
2. Sexual behavior and feelings
3. Reproductive health
4. Relationships
5. Recognition of sexual abuse

6. Self protection strategies

7. Reporting and coping with sexual assault.

**Additional Materials**

The JCCs may use supplementary materials in the delivery of sex offender services at their facilities. These may vary according to the needs of the juveniles and may include:

Pathways: a guided workbook for youth beginning treatment (Safer Society Press, 1990)

Who am I and why am I in treatment?: a guided workbook for clients in evaluation and beginning treatment (Safer Society Press, 1988)

How can I stop? Breaking my deviant cycle: a guided workbook for clients in treatment (Safer Society Press, 1990)

The Relapse Prevention Workbook for Youth in Treatment (Safer Society Press, 1993)

**PRESCRIPTIVE SERVICES**

Prescriptive services were developed at JCCs to meet the treatment needs of the increasing number of sex offenders in the system. Juveniles in prescriptive services reside in the open population at each facility and are brought together for treatment sessions. These juveniles generally have less serious sex offenses than those in self-contained units. However, juveniles on the waiting list for self-contained units may participate in prescriptive services.

**Treatment Objectives**

The juveniles who participate in prescriptive sex offender services address nine treatment objectives. These nine are based on the objectives addressed in the self-contained units. They receive credit for the objectives in group psychotherapy, but may begin addressing them in individual psychotherapy. The objectives are:

1. Autobiography

2. Disclosure

3. Offense Cycle

4. Cognitive Distortions

5. Defense Mechanisms

6. Feelings (Power/Anger)

7. Victim Empathy

8. Personal Objective

9. Relapse Prevention

**Psychoeducational Curriculum**

Prescriptive services use the Psychoeducational Curriculum for Adolescent Sex Offenders (Richardson, Loss, and Ross, 1988), as the foundation of their psychoeducational sessions. Oak Ridge JCC prescriptive services use the LifeFacts curriculum. Both of these curricula are outlined in the previous section of this manual.

## SPECIAL CONSIDERATIONS

### LIMITS OF CONFIDENTIALITY

Juveniles are informed that disclosure of unreported offenses, or past unreported victimization will be reported to the proper agencies. Victims of sex offenses need to be identified so they can receive treatment, and offenders need to be reported to prevent them from offending on others. If juveniles provide any staff member with sufficient information such as names, dates, and addresses of past offenses or victimizations, it is staff's duty to report the information immediately to the program psychologist, social worker, or counselor. The Facility Director is responsible for reporting the information to the proper agencies and determining the procedures for it.

### OFFENDER-VICTIM CONTACT

The juvenile should not have any verbal, written or visual contact with his victim until deemed appropriate by both the juvenile's and the victim's therapists. In most cases, the offender should complete his victim empathy treatment objective. This is very important because premature contact may retraumatize the victim. The initial meeting(s) between an offender and victim must occur in a therapeutic session, usually in family therapy. The session should be structured, the goals clearly outlined, and a therapist should be made available to the victim immediately after the session if needed.

### PERMISSION TO VIDEOTAPE

Some treatment sessions may be videotaped for training, supervisory or teaching purposes. A videotape may be used as a teaching tool for juveniles by playing the tape in group and discussing their performance. Videotapes may be presented to supervisors to help the therapists improve their clinical skills. Tapes may also be used to train others who will work with sex offenders.

Taping is an integral component of the program, and individuals with a legitimate vested interest in the tapes may be allowed to view them. Tapes for training and other purposes will require consent procedures. The person making the tapes is responsible for protecting the confidentiality of the tapes.

### AVERSIVE TREATMENT TECHNIQUES

The Treatment of Adolescent Sex Offenders Committee (TASOC) and the Sex Offender Treatment Advisory Committee approved DJJ sex offenders programs the option to use covert sensitization. This is a well established psychological technique used in the treatment of sex offenders. The technique requires juveniles to mentally pair deviant scenes with aversive scenes. The goal is the deviant scenes will take-on the aversive characteristics, making the deviant scenes less arousing. Covert sensitization is the least intrusive of the many aversive techniques commonly used with sex offenders. Other aversive techniques to control deviant sexual urges must be reviewed and recommended by TASOC and approved by a case by case basis by the BSU Chief Psychologist.

## SUCCESSFUL COMPLETION OF TREATMENT

Juveniles must demonstrate considerable motivation and effort to successfully complete sex offender treatment. They must know the information they learned in the program and apply it to everyday life at the facility. Youth should progress through the phases in the cottage based on their behavior and completion of treatment objectives. By the time they complete the program, they should be on the highest phase in the cottage and/or facility. During the final stage of treatment in the program, staff place full responsibility on the juveniles to prove they have successfully completed the program and reduced their probability of reoffending.

### CRITERIA FOR SUCCESSFUL COMPLETION OF SEX OFFENDER TREATMENT

Juveniles are eligible for successful completion from sex offender treatment if they have met the following criteria:

A. Completed all treatment objectives. Each juvenile is responsible for articulating and defending his accomplishment of the treatment objectives in group psychotherapy and treatment team meeting.

B. Each juvenile is responsible to articulate and exemplify the following (as outlined by the National Adolescent Perpetrator Network in the Juvenile and Family Court Journal, 1993):

1. Acknowledgment of responsibility without denial, minimization, projection or rationalization.
2. Behavioral indications of work toward treatment goals
3. Understanding the contributing factors to offending cycle
4. Positive changes in or resolution of contributing factors to cycle
5. Capacity for victim empathy and empathic thinking
6. Ability to manage stress and modulate negative feelings
7. Improvement in self esteem
8. Increases in positive sexuality
9. Pro-social interactions and involvement with pro-social peers
10. Positive family interactions
11. Openness in examining thoughts, fantasies and behaviors

12. Ability to reduce and maintain control of deviant sexual arousal
13. Reduction of deviant fantasies and increases in healthy non-abusive sexual fantasies
14. Ability to counter irrational thinking
15. Ability to interrupt cycle and seek help when destructive or risk behavior patterns begin
16. Assertiveness and communication skills
17. Resolution of personal victimization or loss issues
18. Ability to experience pleasure in normal activities
19. Ability to communicate and understand behavior patterns in the treatment milieu and correlate them in the home/community
20. Family's ability to recognize the risk factors and help interrupt the juvenile's cycle

Juveniles at Oak Ridge JCC may have difficulty understanding and applying all of the above concepts due to their limited intellectual functioning. This should not interfere with their ability to successfully complete a treatment program, but it means these juveniles may need a more structured and supervised parole plan with a solid treatment component.

When a juvenile has met all the criteria for successful completion, he requests a treatment team meeting. Through a structured interview, the juvenile presents his case for release from the program and answers questions from the treatment team. It is the juvenile's responsibility to demonstrate to the treatment team he has successfully completed the program. Treatment team approves successful completion if the juvenile meets the criteria.

## PROBATION, SUSPENSION AND TERMINATION OF TREATMENT

### PROBATION

A juvenile participating in the program may be placed on probation if he is not making sufficient progress in treatment or is a behavioral problem. Treatment team can place a juvenile on probation as a warning to him that he is at risk for suspension or termination. A juvenile placed on probation is monitored very closely by the treatment team for a period of one month. After one month, the treatment team makes a decision either to take him off probation, suspend him, or recommend termination. A juvenile on probation will receive the same treatment services as juveniles who are in the program. The juvenile may also work toward obtaining his treatment objectives. A behavioral contract may be developed between the youth and treatment staff concerning the areas that need improvement.

A juvenile whom the treatment team has some reservations about accepting into the program, but who displays some potential for becoming an appropriate candidate for treatment, may be a candidate for entering the program on probation. After a one month period, the treatment team decides whether to accept the juvenile or recommend termination, based on the termination criteria.

### SUSPENSION

A juvenile exhibiting behaviors that interfere with his therapeutic progress, but do not

warrant termination, may be placed on suspension. The decision for suspension is made by the treatment team. A treatment team form documents the reason for suspension, and types of improvements needed in the juvenile's behavior. Suspension is limited to fourteen (14) days. A space in the program is reserved for the juvenile while he is suspended. If a juvenile's behavior does not improve within 14 days, he will be a candidate for termination from the self-contained unit.

A juvenile who is suspended does not receive sex offender specific treatment. He is eligible to receive limited psychotherapy that will address his problematic behavior. If a juvenile's behavior does not improve, or if the juvenile displays no motivation for change, the treatment team may recommend termination.

**TERMINATION**

Juveniles may be terminated from the sex offender programs if they do not attain their treatment goals on time or demonstrate inappropriate behavior in the cottage or at the facility. Capacity in the programs is limited, and juveniles must continually earn their space in the programs through motivation and merit. Juveniles may be terminated from the programs for the following reasons:

1. Refuse to participate in treatment.

2. Deny or significantly minimize their sex offending behavior, even after extensive confrontation.

3. Do not demonstrate significant progress in treatment (e.g., have not attained six treatment objectives in nine months, etc.).

4. Display behaviors that risk the safety of themselves, other juveniles or staff.

5. Exhibit behaviors that disrupt the program, or the progress of other juveniles in the program.

6. Were allowed into the program on probation and after one month have not made sufficient progress in attaining probationary goals.

7. A juvenile who engages in inappropriate sexual behaviors.

8. Display a serious disregard for facility rules.

The sex offender treatment team approves termination and the youth may appeal it to the Institutional Review Committee (IRC). The IRC approves cottage transfers and the youth may appeal his cottage transfer to the Central Review Committee (CRC).

## DOCUMENTATION OF SEX

## OFFENDER SERVICES

All BSU written reports and correspondence should be of professional quality, clear and understandable, and signed with name, job title and date.

**INITIAL ASSESSMENT**

The initial sex offender assessment determines the type of services the juvenile will require while at a JCC. The following areas may be addressed in the report: reason for referral; background information; mental status examination; history of sex offending; sex offender interview; discussion; and recommendations.

**MONTHLY REPORTS**

Therapists document on a monthly basis the progress of all sex offenders on their caseload. The report may include the juvenile's progress in treatment, his attainment of treatment objectives, and any significant issues addressed in treatment. The counselors complete a report on the youth every 60 days, which is sent to the youth's court service unit.

**FINAL SUMMARY**

A final summary needs to be completed on all sex offenders that participated in sex offender treatment at JCCs and are considered for release. These reports describe the juvenile's overall progress in treatment, his risk of re-offending and recommendations for continued services. Final reports on juveniles who are classified major offenders are titled Sex Offender Exit Psychological Assessments and consist of the following report headings: (1) reason for referral; (2) psychosocial history; (3) current mental status examination; (4) background information; (5) description of treatment program; (6) analysis of offense; (7) response to treatment; (8) risk factors; (9) risk assessment; and (10) recommendations.

## PAROLE FOR JUVENILES

A therapeutic regime that includes strict parole rules and follow-up treatment significantly increases the likelihood that gains made during treatment will be maintained. Follow-up treatment should be continued for as long as possible for new habits and skills to be reinforced and to monitor compliance with treatment contracts (ATSA, 1993, p.9). The majority of juveniles who complete sex offender treatment at a JCC will require additional community-based treatment. The juvenile's treatment team will work closely with his court services unit and parole officer from the day the juvenile enters treatment at a JCC until he is discharged. When the juvenile has completed the treatment, his treatment team will provide recommendations for continued services. Community based treatment will allow the juvenile to continue addressing issues identified at the JCC, as well as provide a supportive transition into the community.

> It is important that adequate resources be available to promote a successful transition. In order to be effective, aftercare should be as integral a part of the rehabilitative process as initial assessment and treatment. It is the part of treatment that most directly connects with the juvenile's future. It recognizes the potential stress of reintegration and challenges

the juvenile to maintain treatment gains. In essence, aftercare is the transfer of the therapeutic message to daily life in the community . . . The goal of aftercare is to help the offender not re-offend. Cutting the offender loose in one step gives a false message of confidence, undermines the need to monitor self, and may discourage return for additional help. Aftercare and follow-up protect the community's investment in the treatment of sexually abusive juvenile, promote community safety, and are essential to the long-term management and control of sexually abusive behavior (NAPN, 1993, pp.54-55).

## SEX OFFENDER TREATMENT STAFF

### CREDENTIALS

Individuals providing treatment at JCCs should have competency in the area of sex offender treatment by possessing knowledge and skills and the ability to apply them in a clinical setting. They should be "certified" as a sex offender treatment provider under 54.1-2400 of the Code of Virginia, or demonstrate commensurate expertise. Individuals who do not meet the above criteria may practice in a limited capacity under the supervision of a certified sex offender treatment provider.

### TRAINING

All staff working with sex offenders must attend a 3-day sex offender introductory training workshop, which was developed by TASOC and offered by the DJJ Training Unit. The workshop is typically offered in the Spring and Autumn of each year. Sex offender treatment staff also should keep abreast of the most recent developments and trends in sex offender treatment. They are encouraged to attend sex offender treatment training sessions and conferences that would increase their level of expertise and/or improve their treatment methodology.

### STANDARDS OF CARE AND CODE OF PROFESSIONAL ETHICS

Standards of practice specific to practitioners who treat sex offenders are necessary, given the uniqueness of this area of practice, the degree of control that a provider exercises over the lives of sex offer clients, and the community protection issues inherent in this work.

The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all practitioners who provide services to sex offenders. Practitioners shall abide by the standards of practice in accordance with 18 VAC 125-30-100 (VA Department of Health Professions, 1997). These are outlined below:

1. Practice in a manner that ensures community protection and safety.

2. Treat all sex offender clients with dignity and respect, regardless of the nature of their crimes or offenses.

3. Provide only services and use only techniques for which they are qualified by training and

experience.

4. Disclose to sex offender client all experimental methods of treatment and inform client of the risks and benefits of any such treatment.

5. Inform sex offender clients of (i) the purposes of an interview, testing or evaluation session and (ii) the ways in which information obtained in such sessions will be used before asking the sex offender client to reveal personal information or allowing information to be divulged.

6. Inform sex offender clients of circumstances which may allow an exception to the agreed upon confidentiality, including (i) as obligated under dual-client situations, especially in criminal justice or related settings (ii) when the client is a danger to self or others; (iii) when under court order to disclose information; (iv) in cases of suspected child abuse; (v) as otherwise required by law.

7. Not require or seek waivers of privacy or confidentiality beyond the requirements of treatment, training or community safety.

8. Explain to juvenile sex offender clients the rights of their parents and/or guardians to obtain information relating to the sex offender client.

9. Maintain sex offender client records securely, inform all employees of the rules applicable to the applicable level of confidentiality and provide for the destruction of records which are no longer useful.

10. Retain sex offender client records for a minimum of five years from the date of termination of services.

11. Stay abreast of new developments, concepts and practices that are important to providing appropriate professional services.

12. Never engage in dual relationships with sex offender clients, former clients, trainees, and supervisors that could impair professional judgement or compromise the sex offender client's or trainee's well-being, impair the therapist's supervisor's judgement, or increase risk of sex offender client or trainee exploitation. Engaging in sexual intimacies with sex offender clients or former clients, or with current trainees is prohibited.

13. Report to the VA Board of Health Professions and the BSU Chief Psychologist known or suspected violations of the law and regulations governing the practice of sex offender treatment providers, and as well as any information that sex offender treatment provider is unable to practice with reasonable skill and safety because of illness or substance abuse or otherwise poses a danger to himself, the public, or clients.

14. Provide clients with accurate information concerning tests, reports, therapeutic regime and schedules before rendering services.

15. Maintain cooperative and collaborative relationships with corrections/probation/parole officers or any responsible agency for purposes of effective supervision and monitoring of sex offender client's behavior in order to assure public safety.

16. Consider the validity, reliability and appropriateness of assessments selected for use with sex offender clients. Where questions exist about the appropriateness of utilizing a particular assessment to a sex offender client, expert guidance from a knowledgeable, certified sex offender treatment provider shall be sought.

17. Recognize the sensitivity of sexual arousal assessment testing and treatment materials and use them only for the purpose for which they are intended in a controlled penile plethysmographic laboratory assessment.

18. Be aware of the limitations of plethysmography and that plethysmographic data is only meaningful within the context of a comprehensive evaluation and/or treatment process.

19. Be knowledgeable of the limitations of the polygraph and take into account its appropriateness with each individual client and special client population.

20. Comply with all laws in the Code of Virginia applicable to the practice of sex offender treatment providers.

## ADVISORY RESOURCES

Sex offender programs within DJJ have several resources to utilize as they continually modify and improve their programs to meet the changing needs of their populations. These resources ensure the programs are providing services that are in compliance with the standard of care for sex offender treatment. These include:

### THE TREATMENT OF ADOLESCENT SEXUAL OFFENDERS COMMITTEE (TASOC)

The Treatment of Adolescent Sex Offenders Committee (TASOC) is an integral part of services to sex offenders committed to DJJ. TASOC's mission is to provide recommendations for sex offender treatment programs, review and evaluate existing sex offender treatment, and recommend training needs for staff who provide sex offender treatment.

### SEX OFFENDER PROGRAM ACTION COMMITTEE (SOPAC

The Sex Offender Program Action Committee (SOPAC) was initially established in the Department of Corrections to coordinate and regulate sex offender treatment. Its role has expanded and the committee includes representatives from the Department of Corrections, Department of Juvenile Justice, Department of Mental Health, and private practitioners. SOPAC sponsors an annual conference on the treatment of sex offenders. The DJJ sex offender programs utilizes SOPAC as a vehicle for consultation and training.

**ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS (ATSA)**

ATSA is an international organization focused specifically on the development and dissemination of professional standards and practices in the field of sex offender research, evaluation and treatment. It sponsors an annual international research and treatment conference for professionals working with sex offenders.

**VIRGINIA ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS (VATSA)**

VATSA is a state-wide chapter of ATSA that is focused on the development and dissemination of professional standards and practices in the field of sex offender research, evaluation and treatment in Virginia.

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