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EVALUATION OF SEX OFFENDER PROGRAMS THE CALIFORNIA YOUTH AUTHORITY SEPTEMBER 29, 2003

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FINAL REPORT
EVALUATION OF SEX OFFENDER PROGRAMS
THE CALIFORNIA YOUTH AUTHORITY
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This report is the result of an intensive evaluation of the California Youth Authority's sex offender treatment programs and is written to provide answers to the following six areas of inquiry:

1. Does the CYA offer adequate sex offender treatment to all the wards committed to the CYA by a juvenile court for sexual offenses?

2. Have the CYA staff that work with or have contact with sexually offending wards received appropriate training?

3. Does the CYA have an adequate level of staff to implement its sex offender treatment programs?

4. Does the CYA have appropriate policies concerning the provision of sex offender treatment?

5. Thoughts and recommendations on the CYA's transition from a program model to a case management model – Vision and Implementation.

6. Thoughts and recommendations on the CYA's Sex Offender Treatment Work Group

In addition to answering these six questions, I was asked that any recommendations be realistic and practical. My years of experience with social service, correctional, and non profit organizations has served to make me very familiar with these kinds of guidelines.

Too often this mandate actually means to fix the problems without additional funds. In this case I am operating under the assumption that in this case I am being asked to recommend the minimum changes necessary to deliver a safe and adequate program. Adequate simply meaning a program that is supported by standards of practice and guidelines such as those developed by the National Standards on Sex Offense Specific Programs for Adolescents, The National Task Force Report, the Standards developed by the Association for the Treatment of Sexual Abusers, studies and reports from the Center for Sex Offender Management, the vast amount of literature on how to provide successful programs for these youth, and the research to date on assessment, treatment, and risk management. I have attempted to do just that, and if the amount of change required seems large, that is due to the size of the problems.

I have attempted to show in the cost analysis section it why it is realistic and practical to develop and implement a program for all of the juvenile sexual offenders in the California Youth Authority that will have the optimal chance of being successful in decreasing sexually abusive behavior. Doing anything less than this is a mistake both financially and in terms of human suffering. There is no doubt that programs need to be developed and implemented in as cost effective and efficient a way as possible. Realistically, though, creating a program for approximately 1200 sexually abusive wards that will meet nationally recognized standards of care is going to require funding. These funds, however, are a good investment, and one with almost immediate returns

It would be a mistake to apply band-aids to what are systemic problems. Temporary solutions can cloak the symptoms but as a consequence will only allow the underlying problems to spread and grow worse. This steadily raises the costs that will inevitably have to be spent to correct the problems, and steadily raises the immediate costs associated with bandaids - rapid staff turnover, inconsistent treatment delivery, increased training and supervision costs; increased incident and behavior management problems, increased numbers of justifiable lawsuits, and, finally, the increased financial and emotional costs of the aftermath of sexual abuse. These are all the very direct consequences of treatment failure and the failure to treat sexually abusive youth.

I have put months of thought and effort into evaluating both present and planned programs in a way that would be helpful to the California Youth Authority in developing and implementing successful programs for sexually abusive youth. This report contains an excess of educational material because it is assumed that some readers will have no background in responding to and treating sexually abusive youth. That information, of course, will be redundant to those who are very familiar with the problems of treating sexually abusive youth.

The Reviewers Qualifications:

The opinions expressed by this reviewer are based upon the following experience: (1) Membership in the National Task Force on Juvenile Sexual Offending, (2) Collaboration in writing both the National Task Force Report and the Revision, which were solicited

and published by the National Council of Youth and Family Court Judges; (3) Membership on the National Task Force on Sex Offense Specific Residential Standards for Youth, and collaboration in producing the document developed by this task force, the National Sex Offense Standards for Residential Programs; (4) Thirty-three years experience in residential treatment settings with conduct disordered, delinquent, abused and neglected and/or emotionally disturbed youth; (4) Nineteen years experience specializing exclusively in the treatment of child sexual abuse victims, sexually abusive youth, and their respective families; (5) Thirteen years experience as an independent consultant and trainer specializing in the development, implementation, and evaluation of offense specific residential programs for youth; (6) Membership and active participation in the Association for the Treatment of Sexual Abusers since 1990 as well as current membership on the Standards Revision Committee; (8) Membership and active participation in the National Adolescent Perpetration Prevention Network since 1984.

The Investigation Procedure:

In order to answer the six areas of inquiry it was necessary to examine extensive data and documentation, conduct individual interviews with central office staff, facility staff, and CYA wards, observe a variety of program components, and make on site visits to the California Youth Authority Central Office in Sacramento; O.H. Close Correctional Facility in Stockton (the Humboldt Sex Offender Program), Fred C. Nelles Correctional Facility in Whittier (the Carter Sex Offender Program), Ventura Correctional Facility in Ventura, the Northern Reception Center in Sacramento, Preston Youth Center in Ione(the Oaks Program, N. A. Chaderjian Correctional Facility (the Feather Program), and the Sacramento parole office

In addition, professional literature pertaining to sexually abusive juveniles was extensively reviewed which included: all available national and state standards, guidelines or protocols pertaining to the delivery of services and treatment to sexually abusive youth in residential settings; several different sets of professional standards pertaining to the delivery of services in correctional settings; and the Standards of Practice developed by the Association for the Treatment of Sexual Abusers.

The persons interviewed, the documentation reviewed, and the observations made are contained in Addendum A, B and C.

The Difficulties of the Evaluation Process:

Although I think the report is as thorough as possible, the evaluation process was difficult due to a number of circumstances. First, there was a very real difficulty in evaluating a system that has no uniform policies and procedures for the delivery of sex offender treatment programs. The current programs, the operationalization of the programs, and the program materials are all different in each individual program. The resource materials are either developed by the individual program, or copied from a wide variety of sources.

As a result, some of the materials are excellent, some are not, some are outdated, and some are not pertinent to the cultures of the individual wards. While the program staffing patterns were the same for the different programs on paper, it was difficult to determine what this mean in real terms. It was not unusual for staff positions to remain unfilled as a result of either budget problems or the inability to fill the positions. The same can be said of the program modules and schedules.

Secondly, The California Youth Authority serves a population whose age ranges from 13 to 25. As a result of the common practice of increasing time incarcerated, a large cluster of the wards are in the 18, 19, and 20 and over age group. Professional research as well as current literature nearly always refers to one particular age group – children, adolescents or adults, as well as differentiating males and females. Since nearly all of the wards are committed as juveniles, it can be assumed that as a result of living in an isolated correctional setting many of the normal developmental tasks of adolescence do not take place as usual. Even the wards in their twenties may continue to be in an adolescent stage of development. Therefore, although most of the citations used in this report will refer to male adolescents it will probably be pertinent to most of the population. Any information pertaining solely to female offenders or adults will be identified as such.

Another difficulty in conducting the review was in the necessity of assessing the program as it is today, as it was several years ago and as it is planned to be. Question one will address the program as it is today and question six will address the program as planned by the sex offender work group. Even as I was in the process of conducting the assessment, plans for increasing program standards of practice were being made. The CYA Task Force Report is written to correct many of the problems that will be identified in this review. This plan requires budgetary changes and a budget has been submitted but not passed.

On a positive note, the evaluation process was facilitated in a very efficient and helpful manner by the Deborah Johnson and Jack Wallace of the California Youth Authority and Sandra Lusich of the Attorney General's Office. Everything needed to conduct the evaluation was furnished in a timely manner, individuals were cordial and cooperative, and quick access was provided to all materials requested. There was never any obvious attempt at censorship. This reviewer was much appreciative of this.

Executive Summary:

This reviewer's opinion is that the California Youth Authority rehabilitative programs for juvenile sexual offenders does not meet currently recognized standards of practice in the field. That is not to say that there aren't very competent professionals working in the sex offender programs, or that some of the offense specific programming components are not well conceived and delivered. Unfortunately, the programs are missing some critical components, for example a comprehensive assessment, evaluation, and treatment planning policy and procedure. Programs and staff are constantly cut because of budget problems and staff are not regularly trained either in intervening or behavior management

with sexually abusive youth. The staff is not always selected to meet the needs of the wards, but to meet the needs of the staff. Finally, the overall culture of the programs is institutional and punitive rather than rehabilitative.

The failure to treat sexually abusive youth using standards that are commonly utilized by other states can be remedied. The CYA is clearly capable of developing and implementing a program that will meet current standards of practice in the field. However, the CYA does not operate in a vacuum, but is part of a much larger system. What the CYA actually accomplishes depends not only on their own initiative but on whether or not the necessary funding and support is available. In previous years budget requests that would have alleviated some of the problems currently being experienced have always been turned down. This is a matter of record. There is a new budget proposal that would support the Task Force recommendations discussed in question six. However, this reviewer believes that the Task Force Report and Recommendations need to be modified and made broader which would mean analyzing the present budget proposal to see if these changes would require additional funding.

The financial investment is a sound one, however, as research has demonstrated that juvenile sexual offenders are quite capable of change as well as what interventions are the most successful in producing that change. Those interventions that are successful with this population require an integrated program model, treatment interventions that impact directly on the problems that support sexually offending behavior, teaching non offending management strategies, adequate time to affect the internalization and practice of these strategies, and enough competently trained staff selected for the ability to work well with this population. The following data informs us of the soundness of an investment in the successful management of programs for sexually abusive youth.

- 30% of child molestations and 20 % of rapes are committed by juveniles (Federal Bureau of Investigation (1993); Murphy and Page (2000)).

- 33-50% of adult sex offenders began offending in adolescence (Prentky et al. (2000)). 33% of the adult offenders who have no juvenile charges are thought to have committed undetected sex offenses (Prentky and Knight (1993)).

- 46% of juvenile offenders were under 12 at age of onset (Burton (2000)).

- 18% of a sample of 3,000 previously sexually abused men and women were victimized by females (Finklehor (1990)).

- The statistics on recidivism range from just 7% -14% for adolescents who have completed offense specific treatment programs. Rates of non-sexual recidivism are generally higher (25% to 50%) (Becker, (1990)).

Please see Addendum D for information about sexual abuse as a public health problem and about the efficacy of treatment for sexual abusers. See Addendum E for further research based information about sexually abusive youth.

The Costs of Treatment Failure and the Failure to Treat:

There are two very logical and compelling reasons to provide sex offender treatment: doing so protects the public, and provides the most cost-effective services. A 73-100% reduction in recidivism not only protects the public, but, in doing so, will actively save Californians millions of dollars which could be applied to other much needed services. Few other budget requests can promise this.

Robert Prentky, Ph.D. of the Bridgewater Massachusetts Correctional Facility developed a model for program success based upon its overall cost-effectiveness. Included in his calculations were the cost of prosecuting a single instance of recidivism, incarcerating the recidivist, and treating a single victim, compared to the cost of providing appropriate treatment to an offender during their original incarceration. Prentky found that the program at Bridgewater would be cost effective if it merely reduced recidivism by 11%. Applying this model to California, Janice Marques determined that such programs would be cost-effective if they produced only a 14% decrease in recidivism.

It is noteworthy that these estimates are very conservative. Some estimates of the overall costs to society of sexual offending run into the millions per offender, and these estimates aren't unreasonable. A great many of the factors simply aren't quantifiable in advance, thus Dr. Prentky's conservative formula. Yet, the impact upon victims, their families, the human resources, legal, law enforcement, and correctional systems, legal costs to victims and offenders, psychiatric costs to victims and their families, the likely reduction in social and economic contributions of inadequately treated juvenile offenders and their victims alike, and the simple exacerbation of public fears all create a very real and heavy burden upon society in general.

In "The Economics of Implementing Intensive In-prison Sex-offender Treatment Programs" (1999), an Australian Institute of Criminology report, Ron Donato and Martin Shanahan estimated that intangible costs of child sex abuse were ten times the dollar value of tangible costs. The AIC Director, Adam Graycar, verified that the tangible cost savings for Australia per every 100 juvenile sex offenders treated would be $3.98 million per year. The tangible costs of an adjudicated sex offense in California, where it now costs $48,000 per year simply to incarcerate the offender, are higher. Therefore so too, exponentially, would be the amount of money saved by the State and the public at large by the provision of effective juvenile sex offender treatment program to all of the wards who need it. None of the above estimates factored in the tangible and intangible costs to the government and public of lawsuits that are often the result of not providing treatment that meets standards of practice commonly accepted.

Simply put, the provision of appropriate juvenile sex offender treatment within the CYA would significantly reduce the financial and psychological costs of sex offender recidivism to Californians. Sexual victimization is one of the most costly types of recidivism, in all senses.

California has not always failed to provide appropriately for its incarcerated youth. Originally California was a pioneering State both in the difficult field of juvenile sex offender treatment and in juvenile corrections in general. The nation owes California a debt for the great number of professional, programming, and operational standards currently in general practice around the U.S., Canada, Australia, and elsewhere.

A comment often heard from people working in the system was that the CYA's ability to provide appropriate treatment, education and training to juveniles has decreased significantly over the last decade and this is usually attributed to the change to a correctional model. Unfortunately for the state of California it has 12% of the nation's youth and 29% of its incarcerated juveniles. While juvenile crime is increasing in California, it is declining on a national level.

Some might think that California simply can't afford to make the changes and provide the resources needed for even an adequate juvenile sex offender treatment program right now, due to the budget crisis. In truth, for that very reason California can't afford not to. Juvenile sex offenders have been proven capable of leading productive, non-offending lives if they receive appropriate treatment. Given that treatment methods capable of both significantly reducing recidivism and of facilitating the overall rehabilitation of sexually abusive youth currently exist, and that these methods have proven to provide significant returns in government dollars invested then it is both reasonable and prudent to fund sex offender programs that will meet the current standards of practice.

The resources available to change the situation, for juveniles to be rehabilitated, deterred from crime and lead a productive life depends on the ability of policy makers to find creative reforms that can change priorities and commitment patterns.

RECOMMENDATIONS FOR THE CALIFORNIA YOUTH AUTHORITY:

- Fund a permanent position in the Central Office to oversee and monitor the development and implementation of standards of practice for all programs that serve sexually abusive youth. The job responsibilities of this position are outlined in question six.

- Adopt The Sex Offender Task Force Plan with modification. The Task Force plan provides a standardized curriculum, enhanced family involvement, nationally recognized performance standards, enhanced staffing patterns, new psychological testing protocols, new assessment and monitoring tools and new staff training mandates. The details of this plan are outlined in the answers to number six. There are additions to the report that must be made and some considerations that must be pondered. These are discussed in question six.

- Develop a plan of implementation so that there is an action plan for making the changes necessary to bring the programs for all sexually abusive wards in line with nationally recognized standards of practice. The sources for these standards of practice are part of Addendum A under Review of General Information.

- Make the changes necessary to move from a correctional model to a rehabilitative model.

- Additional recommendations include but are not limited to the following:
    - Monies should be allocated by whatever system is legally responsible for doing so, to fund juvenile sex offender programs that meet minimal standards of care, that are comparable to those already developed by other states and by national initiatives.

    - Treat the majority of sexually abusive youth in a therapeutic milieu, using the outpatient model only for those who are able to live within a general population and maintain a non offending lifestyle.

    - Any ward with a history of being sexually abusive in their case records, who has disclosed sexual abusive behavior for the first time while a ward of CYA, or who has committed sexually abusive acts while in the CYA, should have treatment as a sex offender, whether they were initially adjudicated for a sexual crime or not.

    - Develop a method for licensing and accrediting programs and providers along with the appropriate accountability measures for doing so. The ones currently suggested by the Task Force Plan are good.

    - Develop and implement a comprehensive offense specific training program to provide staff that has any responsibility for or interaction with sexually abusive wards the knowledge and skills necessary for the understanding, management and treatment of those wards. Training must be competency based with a way to ensure that the transfer of knowledge has taken place.

    - Include a comprehensive policy and procedure on the assessment and evaluation of all wards who are sexual offenders either within the current reception centers or by the establishment of a special sex offender diagnostic center or centers within the CYA. Use this assessment as the basis for a comprehensive treatment plan for each individual ward.

    - Use thorough risk assessments to ensure that all youth committed to the CYA for sexually abusive acts are being placed in the least restrictive program available to meet their treatment needs and to provide community safety.

- Involve families in all aspects of the treatment program from assessment to discharge.

- Staff the sex offender programs exclusively with individuals who, as verified through accepted and approved industry-testing methods, personally and professionally qualify as those most effective for working with juvenile sex offender populations.

- Develop a behavioral management system that is based on teaching prosocial behaviors while providing logical and consistent consequences for antisocial behavior.

- Develop an integrated program design so that all program components – education, mental health, physical health, vocational and leisure needs, family involvement, etc - will work together to teach non-offending behavior patterns.

- Ensure separate living accommodations and programs for the young adult and adolescent populations

- Develop behaviorally based discharge criteria, which depend upon observable, objective attainment of treatment goals.

- Ensure that every ward discharged has a support group, containment group or relapse prevention group that understands their individual relapse prevention or safety plan.

- Develop and implement a program for sexually abusive females that is gender specific.

- Continue to develop the strategies to provide competent, effective treatment so that the existing waste of resources, program failures, threats to public safety, and drain to the economy are decreased.

- Develop a policy and procedure that requires a pre sentencing assessment prior to placement in the CYA.

- Coordinate with parole from commitment to discharge.

- Develop parole as an extension of treatment and informed supervision.

- Assess wards for substance abuse problems which occur in the context of sexual offending for all sexually abusive youth

- Enlist someone who is an expert (national organizations such as the Association for the Treatment of Sexual Abusers and the Center for Sex

Offender Management are good referral sources) at designing treatment environments for delinquent adolescents in general and juvenile sex offenders in particular to do an analysis of present structures to see what can be modified in the present structure or if a new structure specially designed for sex offenders would be more cost effective.

- Ensure that materials are culturally sensitive and that staff are all culturally competent.

- Ensure that all program materials and resources are appropriate for developmentally delayed wards, wards that cannot read and wards with hearing problems.

- Provide comprehensive case management reviews for the youth who aren't making acceptable progress in treatment in order to make alternative plans.

- Establish vocational and work experience training as part of every sex offender program.

- Consult with some of the medical experts, mental health experts, educational experts and behavior management experts who work with sexually abusive youth in order to develop specific protocols for those areas that take the specific needs of sexually abusive youth into consideration.

- Consider the development of other levels of care under the California Youth Authority, which could be less intensive than institutionalization.

- A quality assurance system operated both from the central office and at the local program level, should be developed to address risk management requirements and performance at a comprehensive systems level for this particular population.

RECOMENDTIONS FOR STATE POLICY CHANGES:

- The CYA should take leadership in the development of an initiative to establish a multidisciplinary multi agency task force whose purpose is to develop a comprehensive statewide plan setting enforceable standards regarding the community's response to sexually abusive youth.

- Develop legislation to establish appropriate minimum standards for sex offender programming and operations, and create a licensing and inspection system. There

has been extremely good work done by other state systems that could serve as guidelines

The Obligation to Provide Juvenile Sex Offender Treatment:

The stated purpose of the California Youth Authority under the revolutionary Youth Correction Authority Act of 1941 was "to protect society by substituting training and treatment for retributive punishment of young persons found guilty of public offenses." By the mid-60s, the success of California's approach had made it not only the norm, but also the formal legal policy of the United States, certified in Kent v. United States (1966) by the U.S. Supreme Court. Though adjustments have taken place to account for the adjudication of juveniles as adults when they commit murders, the Court has maintained the special importance of individually assessing the circumstances of the juveniles before sentencing (Thompson v. Oklahoma, 487 U.S. 815 (1988); Eddings v. Oklahoma, 455 U.S. 104 (1982); Stanford v. Kentucky, 492 U.S. 361 (1989)) the general rehabilitative policy has remained in place. Indeed, the Supreme Court has continued to emphasize the special developmental status of all those under 18 and the obligation to provide them special protection. (Reno v. ACLU, 521 U.S. 844 (1997)).

Citing the U.S. Supreme Court, in P.W.G. v. State (1997), the Florida Supreme Court clarified the purpose of American juvenile justice systems, the role of the juveniles within them, and the legal responsibilities of American judges, lawmakers and authorities:

> "A child offender, even after being adjudged delinquent, is never held to be a criminal, even if the act would be considered a crime if committed by an adult. The key to this difference in approach lies in the juvenile justice systems ultimate aims. Juveniles are considered to be rehabilitatable. They do not need punishment. Their need lies in the area of treatment."

Ironically, the Florida court made this statement in the course of affirming a lower court's decision to order the plaintiff juvenile, who was being tried on unrelated, non-sexual charges, into the offense-specific residential sex offender treatment which the State had failed to provide him despite previous sexual offenses and a professionally identified need.

THE PROGRAM EVALUATION:

ADDRESSING THE SIX AREAS OF INQUIRY:

I was asked to specifically target the program evaluation in such a way that the six questions identified at the beginning of the report would be answered as thoroughly as possible. The rest of this report will be dedicated to doing just that.

1. Question: Does the CYA Offer Adequate Sex Offender Treatment to All of the Wards Committed to the CYA by a Juvenile Court for a Sexual Offense?

Problem: The California Youth Authority does not offer adequate sex offender treatment to all of the Wards committed to the CYA by a Juvenile Court for a Sexual Offense. The second part of the question – is the treatment provided adequate is answered in the next section. At the time I conducted this review, the Department of the Youth Authority was providing treatment for approximately 160 sexually abusive youth – leaving a large number –approximately 900+ offenders untreated. Around 340 wards were on parole and it was not known who had received treatment and who had not without a great deal of research. At that time, The Humboldt Sex Offender Program at O H Close Correctional Facility housed 60 wards and The Carter Sex Offender Program at Fred C. Nelles Youth Correctional Facility housed 50 wards in secure residential settings. Another 45 or so were being treated in intensive treatment or specialized counseling programs. As of July 1, 2003 two other programs were opened: The Feather Program at N. A. Chaderjian Correctional Facility which serves 50 wards and J Company at Herman G Stark Youth Correctional Facility that serves 48 wards bringing the total to 208 beds. This means that approximately 900 sexually abusive youth are paroled without any treatment at all.

The female population identified as sexually abusive were not being counted at all and were not being offered sex offender treatment. The rationale given was that that the numbers were too small to warrant a program. When asked to identify the number of female sex offenders in the California Youth Authority, the answers given varied from one or two to eight or nine. One staff member at Ventura reported that although females didn't come in identified as sexual abusers very often, you could find histories of sexually abusive behavior as you reviewed their charts. It is doubtful that any estimate of the number of female sexual offenders in the California Youth Authority would be valid without a complete review of the charts.

Recommendation: Any ward with a history of being sexually abusive in their case records or who has disclosed sexual abusive behavior for the first time while a ward of CYA, or who has committed sexually abusive treatment while in the CYA, should have treatment as a sexual offender, whether they were initially adjudicated for a sexual crime or not. This is also the recommendation of the Task Force Report.

The CYA should review the charts of all female wards in order to determine if there is any history or suspicion of these wards having committed sexual offenses. Any female

wards identified by this review as sexually abusive should then complete a sex offender specific assessment in order to determine their treatment needs. Treatment plans should reflect offense specific problems and goals. The female wards identified should be part of an offense specific program that is gender based.

Problem: The sex offender treatment programs are not adequate for several reasons. Even though they are inadequate, a number wards benefit from the programs due to the possible occurrence of a number of variables: the dedication of a number of overworked but competent staff and the characteristics of the youth themselves.

What is at the basis of this failure to delivery offense specific programming to all the wards that need this intervention? There are extremely competent people within the CYA. There are also programs and pieces of programs that are really excellent. Some of the vocational programs, for example, are excellent. I had the pleasure of benefiting from the culinary program while at Preston and was very impressed by the quality of the food and the professionalism of the young waiters. The need for community reintegration is basic to sex offender programs. However, most of the vocational programs are not open to the sexually abusive youth. At Fred C. Nelles I was pleased to hear about the effort to provide for the spiritual needs of wards who represented a large variety of religions. The use of spirituality as part of value building is a common part of many sex offender programs and I am referring to the need for a belief in a system of values. At O. H. Close I learned about the use of sweat lodges as a therapeutic intervention – honoring the Native Americans within the program and are a common and acceptable part of sex offender programming in programs for Native Americans. At Ventura I observed a group of boys attending a sex offender specific group on a voluntary basis. They were eager for help and quite astute as to their needs for maintaining a non offending lifestyle. I attended therapy groups at Humboldt, Carter, Ventura and Preston, without prior notice. The therapists were good and the groups were excellent. At the Northern Clinic I observed a meeting to discuss collaboration between the youth authority and the San Francisco parole office. At the Central Office, I spent time with three people who knew as much about sex offender treatment as anyone – Kip Lowe, Jack Wallace and Deborah Johnson.

Despite the talent and ability within the California Youth Authority and the presence of a number of really excellent rehabilitative program components, the sex offender programs are just not what they should be. At this time the CYA is offering treatment interventions to sexually abusive wards in short episodes, and often in facilities distant from their homes and therefore from many of the support, monitoring and oversight resources they will need both during treatment and upon release. The programs, which do exist, are as good as the staff on shift at any one moment in time, and change as the staff change. Unfortunately, bits and pieces do not constitute a total program. The programs are a hodgepodge and just do not meet current standards of practice, even minimal ones. The programs are understaffed, there is a lot of staff turnover, some of the staff is not appropriate to work with this population and some are not trained to do so. Even some of

the program currently planned is not being delivered – and the reasons cited are consistent – it's not in the budget, they haven't replaced that staff yet, they aren't trained, they don't hire staff for their abilities but for their seniority, there is no oversight, there is no consistency, there is just not enough time!

As a group, the psychologists in the program are well trained and very competent. However, there are either not enough of them and or job descriptions are unreasonable as far as a forty or fifty hour week are concerned. In addition some of the job requirements are not related directly to the clinical work for which they are qualified. If California only had a small population of juvenile sex offender wards, with the current resources and qualified staff available you could operate one of the best small treatment programs in the nation. The actual population and resource numbers, however, have created a situation which has limited California's ability to provide the necessary standard of programming.

A number of staff repeatedly told me that there were not enough qualified staff, training, treatment modalities, and resources to provide an adequate program. They did not even mention the conditions of the physical plants, which are dreadful. Comments from both wards and staff were to the point:

Wards:

- "There's not enough treatment time".
- "The majority of the time there is nothing to do and we just sit on our bunks".
- "There's lots of stuff that shouldn't happen and it gets covered up"

Staff:

- "A great deal of criminal activity goes on – gambling, lying, stealing, manipulation through threat, and illicit trade"
- "I would like to stay with the department but there is not enough training, not enough programs- it's a shame because the program really works when they have the time to put it in place"

Recommendation: The sex offender work group completed its work in May with the development of a comprehensive program design for all sexually abusive youth within the CYA. Following this the work group offered training to at least 45 staff in the delivery of this program. This is a good start towards developing a program that meets minimal standards of practice. I met with this group several times. It was my impression that the work group developed a plan that not only met as many minimal standards of practice as possible while keeping in mind what they thought would be realistic as far as a budget request was concerned. There are a number of areas that need to be strengthened and I have made recommendations to cover those areas.

One of those recommendations has to do with monitoring the programs and staff on a regular basis as a risk management and accountability measure. Some states certify both practioners and programs as pare of this monitoring process. Alan Listiak, Ph.D. Coordinator of Sex Offender Program Certification, Minnesota Department of Corrections in an informal correspondence says:

> "In Minnesota there is no individual certification/licensure for providers of sex offender treatment. The tack taken here is to certify at the program level using standards that define: staff requirements; staff qualifications; admissions and intake assessments; treatment plans; client progress; discharge; standards of service delivery; program standards; quality assurance/program improvement. The process is regulated by the Department of Corrections and programs apply to the Department and are then reviewed on site for compliance.
>
> The movement was started at the legislative level by an effort to develop a sex offender treatment system in the state that was tied to a "treatment fund." There was a need to have programs and providers be accountable for payments from the fund. At the time, only a couple of treatment providers and/or persons savvy about sex offender treatment were involved. The system was intended to model itself after the way chemical dependency treatment was provided in the state. It turned out that the sex offender system could not parallel the chemical dependent model for a variety of reasons and, ultimately, the sex offender treatment fund went away. A system of grants and contracts already in place became the sole funding source at the state level.. The certification was to apply to both outpatient and inpatient sex offender treatment programs, both juvenile and adult. After more several years of discussion and argument, the legislature rescinded the requirement to certify outpatient programs, leaving inpatient/residential programs, both juvenile and adult, under the authorizing legislation.
>
> The standards for juvenile and adult programs each had their own public advisory committee (with most stakeholders involved, including providers) and followed the procedures for promulgating administrative law in Minnesota. This included public notice and the development of a document entitled a Statement of Need and Reasonableness that presented the need for and reasonableness of every item in the standards, along with a financial impact analysis, that was submitted to the administrative law judge."

What Kind of Treatment is Adequate Treatment?

Treatment must be offense specific. "Offense specific treatment is distinguished from other kinds of interventions because it crosses the line between the treatment of criminal behavior and the treatment of mental health and behavioral disorders" (Rich (2003)). The result is an approach that is a melding of these disciplines into a multidisciplinary methodology which is specifically designed to effectively change sexually abusive patterns of behavior and stop future victimization. This is a specialized discipline called sex offender specific treatment or offense specific treatment. The National Task Force on Juvenile Sexual Offending (1993) states that the interface between the mental health and criminal justice system is necessary for a sound public policy in regard to sexually abusive youth.

In addition, offense specific treatment should take place in the least restrictive environment needed to ensure community protection and provide the offender the level of treatment required. Only individuals who require severe restrictions in order to manage their level of risk to the community should be housed in secure correctional or mental health facilities.

Recommendation: Standards of practice, protocols or guidelines for sex offense specific treatment programs have been developed and implemented by the states of Colorado, Oregon, Illinois, Massachusetts, Wisconsin, Minnesota, Utah, Virginal, Texas and South Carolina. There may be others as well. This is an excellent opportunity for California and the California Youth Authority to take leadership in an initiative to bring together a multi agency multidisciplinary task force to develop uniform interventions so that these agencies can work together more efficiently in establishing a coordinated delivery of services to juvenile sex offenders.

It is also an opportunity for CYA to explore the possibility of providing different levels of programming. A continuum of services for sexually abusive or aggressive individuals, covering a range of treatment intensities and community access would be more cost effective than what is presently offered.

What are Levels of Intervention?

Presently, the California Youth authority's level of interventions are composed of a track for sexually abusive youth in the intensive treatment programs, in the specialized counseling programs, and the most restrictive possible – two secure residential programs.

Different levels of intervention are needed because sexually abusive youth are a very heterogeneous group. They range along a continuum from the naïve experimenter to the criminally sadistic, and from the developmentally delayed to the gifted. Different types of sexually abusive youth need different levels and intensity of intervention. This not only more effectively addresses each youth's particular level of risk and treatment needs,

but is more cost effective as well. Some states will not contract for services with any agency that does not have a continuum of care.

However, in order to determine the specific level of intervention required by each youth it is necessary to conduct offense specific assessments which are periodically updated. Without such assessments it is almost impossible to make solid recommendations

regarding the environmental restrictions necessary to safely treat an individual. The youth's sexually abusive behavior pattern is only one of the variables to consider in making placement decisions.

To explain: A continuum of care includes a range of sequenced services from least to most intensive, and from least to most restrictive. This allows a youth to move up or down from one level to another based on treatment progress or regression, and allows providers to closely match treatment to the specific needs of each youth. An effective continuum of care can be provided by one entity/agency/organization or by several agencies working collaboratively.

Dr. Steve Bengis was the first professional in the field of sexual aggression to suggest the efficacy of a continuum of care for this population, and he identified a number of levels which included locked secure programs, community based treatment, residential treatment settings, specialized foster care, supervised apartments, special education day schools, and specialized vocational programs. This list is often modified by individual states to meet their own particular needs.

Two of the first states to develop statewide continuums of care were the states of Utah and Oregon. Their designs identified a comprehensive continuum of care, the admission criteria for each level, the amount and intensity of programming and staffing necessary, and the security of the perimeter required.

After reviewing several ward charts which were picked randomly, it was my opinion that some of those wards would be better served in less restrictive and more appropriate environments. Perhaps not all of the juvenile sexual offenders who become wards of the California Youth Authority require the extremely intensive, restrictive, and expensive treatment environment of a parameter secure correctional facility. If this is concerning after the review of only a few charts, one wonders what a more thorough review would find. However, this will require an extensive review or change in assessment procedure in order to determine this.

A pilot program in Jefferson County, Colorado directs youth arrested for sex offenses directly to an assessment center. There a risk screening instrument is administered in order to determine whether the youth should be detained in a secure setting, returned to the home, or transferred to alternative placement (foster, group home, etc) while they receive sex offender specific treatment. The assessment center works with the family and youth, and can refer family members to community counseling, if necessary. Under this system, treatment can start before sentencing occurs. Jefferson County has also

made a concerted effort to bring all delinquent residents of that county home for services. This was decided after research determined that those youth with family involvement were more successful than those who did not have any support system.

Recommendation: The CYA should conduct an extensive review of charts to determine if wards currently incarcerated could be placed in a less intensive level of care.

If the recommendations concerning assessments are put into practice, this could avoid errors in placement in the future.

Does the Physical Environment Matter?

When the physical environment of a program determines the program interventions, then the program begins in a one down position. The program's effectiveness and efficiency – in terms of treatment success and cost - can be seriously undermined when the program must adapt to the physical environment, when behavior management is dependent on the program environment and its configuration, and when the environment is conducive to serious incidents such as suicide, sexual acting out, gambling, drugs, and violence etc.

Even by prison standards the physical environment of the CYA institutions is not good. Program evaluations always include time evaluating the physical environment for risk management issues that are specific to sexually abusive youth. Time did not allow for anything other than a standard walk through which in itself was enough to see that the environment wasn't conducive to ease of supervision, the socializing of unsocialized youth, or teaching groups and organizing activities.

This is not to suggest that the environment should be fancy or anything but utilitarian, designed to meet basic human needs, and promote the ease of program delivery and safety. Just a few of the following are examples:

- In one program showers and toilets in one facility are closed from the ward's common living spaces by torn curtains. This lack of privacy encourages voyeurism, sexual fantasizing and sexual acting out. This is not acceptable in a sex offender program for obvious reasons.
- In one program 50 youth are house in one large room with beds back to back against the wall. The supervision is primarily by one person in a tower overlooking the room. Youths reported not feeling safe, being kept awake by wards masturbating, or such things as wetting the bed but being afraid to get up, etc.
- In one program wards complained of being locked in cells for long periods of time when there is no program or staff to attend to them outside the cells.
- Many wards interviewed complained of cold water, bad smells, mildew and mold, no heat, feeling unsafe, having no privacy. Etc.

Recommendation: The CYA should have someone who is an expert at designing treatment environments for delinquent adolescents in general and juvenile sex

offenders in particular do an analysis of present structures to see if modifications in the present structures will suffice or if a new structure specially designed for sex offenders would be more cost effective. There are several research based studies on the effect of the physical environment on the change process. Correctional institutions are moving away from the huge concrete block like facilities and building smaller facilities that are easier to supervise and keep safe.

What about Mixing Populations of Adolescent and Adult Wards?

The CYA serves a population from 13 to 25. This is a wide difference, and includes age groups with significant developmental and experiential differences. Naturally, this causes problems in housing, in resource allocation, in appropriate staff and ward training, etc. Population management does make a concerted effort to keep the age range in any one program to no more than four years, but this is very difficult with all of the other considerations which must be accommodated. When there is a wide age range in one setting there is always danger that the older and more powerful wards will abuse the younger wards, and it is widely accepted that such abuse is not uncommon in institutional settings. One older ward interviewed at Ventura had been moved from one unit to another because she had been predatory towards younger wards in the first unit. When questioned she acknowledged that she did have a problem and was a danger to younger girls. While this was certainly a good decision it is one that could have been made prior to placement with a thorough assessment protocol on the current risk of dangerousness for appropriate placement. It could also have been used as a therapeutic and safety issue if this ward had been in an offense specific program. Moving the client will protect the younger wards but will do nothing to eliminate the behavior.

There are some similarities between adult and adolescents who sexually abuse but there are also striking differences, which make it critical that they be treated in programs that are developed specifically for their age groups. The similarities are in the patterns of emotional, cognitive and behavioral interactions preceding and following the abusive behaviors as well as similar etiological factors. Both adults and juveniles have had experiences of maltreatment or neglect, trauma and witnessing violence, disrupted attachments, loss, dysfunctional role models and co-occurring disorders. (Ryan and Lane, (1997)).

One thing remains unclear though – how many of the wards over 18 are actually still adolescents developmentally? If they have been institutionalized all of their adolescence then it is quite possible that wards may be chronologically adults but developmentally 15 or 16. This is unknown, however, but a very important point in decision making.

The differences between adolescents and adults are primarily related to human growth and development, the greater flexibility of youth, and the briefer history of the offending mentality and behavior in younger offenders. This greater amenability to treatment of younger offenders is what makes a commitment to early intervention so practical. Adults more often have deviant sexual fantasies and or arousal, and elaborate defenses that deny, rationalize, minimize or distort their beliefs about the nature of their behaviors and they

are more deeply ingrained. The sexually abusive adolescent is much less likely to be associated with deviant arousal (Hunter (1996)) and is still amenable to a change of behavior.

The goals in current treatment approaches for adult sexual abusers are predicated on concepts of lifelong management strategies. For adolescents the treatment interventions are delivered with the expectations that the youth can develop the life coping skills necessary to lead a prosocial life, to develop an internal sense of personal competence, control and responsibility, develop a positive sexual identity, and develop the ability to create non-abusive relationships.

Recommendation: Although it is unclear whether the age group 19 to 25 is developmentally mature as well as physically mature, it is a serious consideration nonetheless. The continuing efforts to keep these populations separated should be monitored closely and receive greater priority and support. When it is necessary for reasons beyond the CYA's control to house a few older wards with the younger wards there should be safety programs designed specifically for that situation. It is not acceptable to house a few younger wards with primarily older wards because the risk factors are so high. In addition, assessments and resources are different for the adolescents and young adults. This should be a matter of concern and attention while planning programs. One example is the vocational training program – there is a need of the young adults who will be joining the work force for vocational training that prepares them to do this. For the younger wards a vocational training program based on understanding all of the issues involved in entering the work world – such as hygiene, communication skill, etc. may be a sufficient start.

What are the Program Components of Offense Specific Treatment?

An offense specific program is generally composed of three major parts – Assessment and Evaluation, Multimodal Multi-Disciplinary Treatment, and Aftercare Monitoring.

1. Assessments and Evaluation:

Presently, the CYA conducts initial assessments at the reception centers. The Intensive Treatment Programs and the Specialized Counseling Programs conduct much more extensive assessments once the ward is in their respective programs. None of these, however, are offense specific. CYA uses one sex offense specific assessment tool, a document that they have developed themselves, the Sex Offender Referral Document. Although SORD is not research based or validated it has been carefully developed and has served the purpose of identifying the wards that need to be placed in the limited number of treatment spaces available in the Youth Authority. Used alone, however, SORD is not always a reliable indicator, although it could be useful as part of an assessment package. If during a ward's placement in a sex offender program the psychologist has the time and resources they can conduct other assessments as needed. These are currently done in only the most serious cases.

In the words of a staff member: "Decisions are currently made based on monetary rather than treatment concerns. Professionals working with sex offenders have to work within those guidelines, doing the best that they can with what they have, but knowing either that its not good enough or a poor compromise"

In order to make informed placement and treatment decisions for sexually abusive or aggressive individuals, juvenile or adult, one must be able to assess numerous sources of information in order to evaluate an individual's risk of re-offending, his/ her danger to the community, and the appropriate level of clinical intervention and supervision required.

The Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice (Righthand and Welch (2001)) states that comprehensive clinical assessments are required in order to determine risk and facilitate treatment, and emphasizes that any attempt to explain or treat juvenile sex offenders must be based on the specific factors pertinent to the juveniles' offenses and individual psychology. To meet minimum standards, the CYA assessment and evaluation procedure must involve a battery of tests (validated by research) in addition to the SORD in order to determine the most appropriate placement and treatment protocol. Assessments must be administered by trained and supervised staff. Even though CYA staff has been trained to conduct the SORD, in one facility a staff member after completing a SORD placed a ward in a sex offender group. This staff had been trained in the use of the SORD. In reviewing the ward's chart with the psychologist at the facility, we found numerous incidents of personal victimization but none of victimizing others.

There are six areas of assessment that should be conducted with sexually abusive youth: pretrial/investigative; pre-sentencing risk prognosis; post-adjudication/ disposition/ needs-based treatment planning and treatment evaluation; pre- discharge; and, monitoring/ follow up (The National Task Force Report (1993)). A CYA policy and procedure on assessments could require these as well as the identified instruments to use.

The areas needing assessment identified by the State of Colorado Sex Offender Management Board are typical of those identified both in the literature, professional standards, and by other states? The Colorado Sex Offender Management Board developed State standards for interventions with sexually abusive youth and adults in 2001 and 2002. These were developed by local experts and national consultants representing a variety of relevant disciplines and agencies with funding from the Center for Sex Offender Management in Washington, DC. The resulting standard of practice for assessment identified the following areas of focus:

> "Current mental status; stress/coping strategies; sexual deviance; denial; stability in current living situation; academic and vocational issues; communication and problem solving skills; social support; acting out behaviors; cognitive distortions; current family composition; history of divorce/separation in family; current mental illness; drug and alcohol use; cultural issues; the complete sexual history including sexual knowledge (where learned); sex education history; non-

offending sexual history; masturbation (age of onset, frequency, fantasies); sexual compulsivity/ impulsivity, sexual victimization; range of sexual behaviors; sexual arousal/interest; sexual preference/ orientation; sexual dysfunctions; sexual attitudes/distortions (i.e. hyper-masculinity); types of sexually abusive behavior the youth has committed; indications of progression over time; level of aggression; frequency of behavior; style and type of victim access; preferred victim type; associated arousal patterns; changes in sexual abuse behaviors or related thinking; the individual's intent and motivation for offending; the extent of the youth's openness and honesty; internal and external risk factors; victim empathy; victim selection characteristics; other adjudications and offenses; non-charged offenses; property offenses; typology, risk to self; denial of offense; risk to others; criminal behavior and conduct; risk for sexual recidivism and protective factors; native environment; living situation; friends and associates; extra curricular activities; awareness and internalization of the impact of behavior on victims and others; any other adjudications; attribution of responsibility; external support; long range planning; readiness for services; and, attribution of responsibility."

In addition, Colorado has also identified many of the options available for gathering this information, including clinical interviews, evaluation tests and instruments, surveys, self-report instruments, and sources of collaborative information.

Recommendation: The California Youth Authority should review both the research and the literature, as well national and state policies already developed as possible guidelines for a state wide policy regarding assessment. The recommendations that the Task Force made regarding a proposed assessment protocol are good but could be more comprehensive. Suggestions for additions will be made in a later part of the review.

In 1986, in a document entitled "Sex Offender Task Force Report" Recommendation No. 1 stated the following: "An assessment procedure should be established at the reception centers to identify the various levels of need for control and treatment of each sex offender." This document makes another 39 recommendations – most of which have not been followed.

What Is The Purpose of Assessment?

Assessment is necessary to inform the treatment planning guidelines. Moving forward without a treatment plan is like trying to guide a car with no headlights down a dark country road.

The only individualized treatment planning taking place in the California Youth Authority presently is in the special programs. These are not always sex offender specific and may vary from institution to institution. As of 1/1/04 there is a plan to implement an individualized treatment plan for each ward. This does not include sex offender specific treatment planning.

Assessment and evaluation form the basis for an individualized treatment plan, considered a fundamental and routine component of any sex offender treatment program. Treatment planning requires analytical and critical thought about problem definition and the choice of therapeutic interventions objectively best suited for overcoming an individual's specific problems. Treatment plans serve as a structured road map for the ward, the treatment team, the family, the parole officer, the court and any others involved or with an interest in the treatment process. It indicates the intermediary problems between the present state of the ward and the ultimate goals, what is going to be done to overcome the problems, what progress is made toward achieving treatment goals, and who is responsible for planning and executing these interventions. The treatment plan is stated in behavioral terms, with measurable objectives. There is nothing vague about a treatment plan, and as a result both the ward, therapists, program staff, and others concerned are concentrating on the same specifically stated objectives and specified interventions. When the ward, treatment team, and anyone else involved in the case reviews this plan at regular intervals, it creates a benchmark of progress that everyone can understand.

Treatment plans for sexually abusive/aggressive youth reflect not only the treatment issues that are typical for sexual abusers, but also focus on whatever unique collateral characteristics the individual may have. Sometimes those collateral treatment issues may be as important to preventing re-offending as the more generic offense-specific issues.

Having a treatment plan means that treatment is goal-oriented at all times, and the focus is kept on achieving that goal. Discharge from treatment will be based on objectively measurable, behavioral progress toward objectives and goals.

Recommendation: It is my understanding that the CYA has recognized a need for treatment plans that are individualized and began developing a model for this in January 2003. The CYA should also develop a treatment plan design that is offense specific but can be individualized to meet the needs of the different wards. The treatment plan should state the goals and objectives and the interventions made to meet them as well as the individual that is responsible for those interventions. It must be stated in behavioral terms and measurable objectives and updated at regular intervals. The ward, the treatment team, the ward's family if available should all be involved in creating the plan and in the periodic review of the plan. The plan is not static but a growing changing document.

2. Multimodal Multidisciplinary Treatment Program:

The California Youth Authority has several separate and distinct sex offender programs housed in several different institutions. These programs serve approximately twenty percent of the sexually abusive youth housed in the California Youth authority. The programs have operated autonomously and there has been no uniform plan for programming.

A. Treatment Modalities: It is a basic standard of practice for offense specific treatment programs to offer a combination of treatment modalities in the context of a therapeutic milieu. The common modalities are: individual therapy; family therapy; group therapy; deviant arousal reduction; sex education/sexual values; psycho educational groups; life coping- skills training; anger management training; conflict resolution and problem solving training; interpersonal skills training; communication training and/ or therapy; assertiveness training; instruction in empathy building; instruction in identifying and expressing feelings; social skills training; parenting training; and, therapies which focus on relapse prevention.

In order to understand how CYA compares with the national averages regarding program components and philosophies, we need to look at the data collected by the Safer Society Foundation, Inc in 2000 from 91 offense specific residential programs for male juveniles (Juvenile corrections 26.1%, acute care 7.6%, court sponsored 8.7%, group home 28.3%, halfway house 2.2%). The survey revealed that the most common treatment modalities and the average time spent on them per week were as follows: Individual Sessions: 1.27 hours; Group Sessions: 3.7 hours; and, Family Sessions .81 hours). In contrast CYA programs offer no individual sessions, 1-2 hours of group sessions per week, and no family sessions except on very rare occasions.

The Safer Society survey also revealed that many treatment programs involved offenders in community service (59%), in contributing monetarily to victim treatment (29.3%), and in structured written apologies to victims (82%). The CYA programs include community service and contributions to victims, but do not have victim apology sessions. Victims and their families are invited to parole hearings, and are asked to share whatever they want to. The parole hearing that I attended was extremely well handled. According to the staff at this facility, not all parole hearings are this professionally conducted. This particular one was conducted by two astute and knowledgeable individuals.

The Safer Survey further found that relapse prevention was used by 94% of the treatment programs, educational classes 89%, cognitive restructuring 89%, arousal reconditioning 81%, adjunctive treatment 83%, and medications as specifically required 60%. Although all of these are offered, the deficits have to do with the amount of time devoted to each activity, the amount of training of individuals delivering the activities, the competency of those individuals, the validity of the resources and the number of sessions possible because of staffing problems. This is not to indicate that there are not some competent well trained individuals providing very good treatment services but that it is not a standard.

A combination of the following educational or therapeutic activities were also typically offered: anger/aggression management, art therapies, drama therapies, experiential therapies, (wilderness outings, ropes course, role plays, etc), relationship skills and physiological monitoring, assault cycle, victim empathy (teaching to care about your own feelings and those of others), sex education, victim restitution, and personal victimization/trauma, assault cycle, victim clarification. Anger/aggression management,

relationship skills, assault cycle, victim empathy and restitution, sex education, personal victimization/trauma, assault cycle, are all components that are offered. The consistency, the competency, the lack of updated materials is the deficits. Art therapies, drama therapies, and experiential therapies are not offered. These therapies are not essential to a program but are thought to work particularly well with a population that has difficulty in expression verbally and on a feeling level.

Accreditation or licensure was achieved by 78% of the programs surveyed. This is not the case with the CYA programs for sexually abusive youth.

B. Family Involvement: At the present time the CYA's involvement of the family in sex offender programs is. almost non existent with a few exceptions. There is family visitation on the weekend at all of the institutions, family night at Carter when there is staff available, and on rare occasions family therapy. At OH Close, three families interviewed during one weekend visitation stated that they had never had any contact at all from the staff at the Humboldt sex offender program. All indicated that they would like to have basic treatment information, and that they would be willing to be involved in treatment if asked. One family spoke no English and their son informed me that he was not aware of any staff on the Humboldt program that spoke Spanish. To be fair, the present job responsibilities of the therapists at Humboldt do not allow opportunity for any family involvement, much less treatment, to be developed. Besides an already overwhelming schedule, there are also systemic problems – such as the fact that at the Humboldt program three therapists share one phone line.

The development of a formal program for family involvement is extremely important. Often there are family dynamics which allowed, contributed, or supported the

development of offending behavior and mentality. Identifying, interrupting and replacing those patterns of behavior with patterns of behavior that support non-offending is a major goal of family treatment. It is not realistic for us to expect a youth to change or maintain changes with a sabotaging or non-supportive family, particularly if the individual is to return to that family setting. It is also no more realistic to expect the families of discharged offenders to understand how to provide effective support and oversight, than it is to expect under-funded, unqualified and/ or inadequately trained staff to do so prior to discharge. "Treatment programs for juvenile sexual offenders must develop methods to help families look at and understand how their beliefs and values have influenced the beliefs, behavior and relationship of their turn contributed to the sexually abusive behavior of their child. (Barnes and Hughes, (2002))

If there has been sibling incest, by and/ or against the ward, then a specialized family reunification procedure must be followed, and social services involved, prior to any decision to return the ward to the home upon discharge if the victim resides in the home.

Offense specific family treatment services encompass a variety of options which can be tailored to a particular family and ward's needs. Involvement in treatment may include

family contracting, individual family therapy, multifamily therapy, psycho-educational or support groups, family working visits in the facility, visits monitored by the family therapist, facility visitation, therapeutic home visitation during the pre-discharge stage, and the provision of a family information packet or manual. All of these components are not necessary in order to have a successful family program but will offer program options which they can then utilize as they see fit.

The following research will help in understanding the issues that need to be addressed in family treatment:

- Familial characteristics that are common include instability, disorganization and violence (Bagley and Shewchuk-Dann (1991); Miner, Sieker, and Ackland (1997); Morenz and Becker (1995)).
- Family characteristics discovered form a retrospective of 51 cases: lack of sexual boundaries – 25%, presence of sexually explicit materials – 33%.
- Miner, Siekert, and Ackland's (1997) study of incarcerated offenders revealed that only 16 percent of incarcerated juveniles came from intact families. Rates do vary, however, in other stories. They also described the juvenile sex offenders in their sample as coming from "chaotic" family environments.
- Communication styles in the families of sexually abusive youth tend to be negative and non supportive. ((Blaske, Borduin, Henggeler, and Mann, as cited in Morenz and Becker, (1995)).
- Smith and Israel (1987) found that some parents of juveniles who sexually abused their siblings were physically and/or emotionally inaccessible and distant.
- Kobayashi et al. (1995) found that more positive relationships between juveniles and their mothers may be related to decreased levels of sexual aggression in juveniles.
- Weinrott (1996) reported there is strong evidence that family instability and problems in parent-child attachment in childhood are associated with more intrusive forms of juvenile sex offending.
- "The families of children who engaged in sexually aggressive behavior tended to be characterized as dysfunctional, evidencing high rates of parental separation, domestic violence, substance abuse, highly sexualized environments (e.g., exposing children to sexual activity, pornography, and both covert and overt sexual abuse), unsatisfactory role models, poor parent-child relationships, parental histories of childhood abuse, and so on (Araji, (1997)).
- After review "The evidence . . . points to family interactions as a primary source of the problem" (Araji, (1997)).

It is not realistic to expect any individual to change or maintain changes with a sabotaging or non-supportive family, if the individual is to return to that family setting or even remain in close contact with their families. Even if the individual is not to return to the family setting the unresolved issues of past family dynamics must have closure of some kind. "Family therapy facilitates the learning of new ways of communicating and building a support system, which will help interrupt the abuse cycle and ultimately be

supportive to the offenders' capacity for resulting and modulating aggressive sexual behavior." (Bernet and Duncan, (1999)).

Still, some people have a problem understanding the correlation between family involvement and success in treatment. In a conversation that will never be forgotten, a program administrator in Tennessee complained to me, "I don't understand why juveniles leave here doing really well, go home to their families, and then everything that we have done falls apart". This program, of course, provided no family treatment.

Recommendation: "Families should be involved in all aspects of intervention beginning with the assessment process" (Moreno and Becker, 1995). The CYA should conduct a needs assessment to ascertain how many wards will be going home, how many will be returning to a home that contains the siblings that they abused, how many families would be willing to be involved in treatment, as well as other important information that might be important to know if planning a family treatment program. After this information is obtained, then a family treatment program can be developed that meets the needs of the wards as well as the limitations of any particular institution. It is obvious from what we know about the families of these youth, and the important role that families play in their lives, that we must attempt to involve the families in treatment. It may mean that the therapist has to spend some time engaging the family members, as many families are reluctant to participate because of their shame and humiliation about the crime. As Stevenson and Wimberley (1990) said, "The importance of family influences in the life of the adolescent sex offender cannot be underestimated as it is often the barometer of what can or cannot happen in treatment"

C. Substance Abuse Interventions: The CYA has a limited amount of substance abuse programs and it is not unusual for there to be a waiting period for space. Substance abuse assessments are regularly conducted but it has not been the practice to evaluate substance abuse in the context of sexual offending or for its impact on sexual offending. Yet, as Lightfoot and Barbaree (1993) have suggested, assessments of juveniles who have committed sex offenses would do better to determine not simply whether substance abuse is present in a juvenile's life but whether it is a risk factor for offending. If it is found to be a risk factor, the next step is to evaluate what interventions are required to reduce this risk.

Without an adequate assessment of substance abuse problems there is no way to differentiate between substance abuse problems that are "normative" experimentation, substance abuse that is a real addictive problem and substance abuse that is a risk factor for sexual offending. . Even among adolescents who are infrequent substance abusers, issues such as poor impulse control, problem-solving difficulties, and poor social skills can be exacerbated by even small amounts of substance and, consequently, may increase the risk of sexually abusing (Lightfoot and Barbaree, (1993)). They also suggested that less frequent users may benefit from substance abuse treatment efforts that are part of a

comprehensive treatment program, but more chronic users may require intensive substance abuse treatment efforts, possibly prior to treatment related to sex offending.

Becker and Stein (as cited in Hunter and Becker, 1994) found that although 62 percent of the juvenile sex offenders in their study admitted to alcohol use, only 11 percent reported that alcohol use increased their sexual arousal. Statistical analyses indicated that the juveniles who reported increased arousal had more victims than those who said alcohol had no effect on their arousal or who said they did not drink. Illicit drug use was less commonly reported than alcohol use among these juveniles: 39 percent reported illicit drug use. Of these, approximately 23 percent reported that it increased their sexual arousal.

Recommendation: The CYA should assess substance abuse problems in the context of sexual offending for all sexually abusive youth. Assessments have been developed that can differentiate between infrequent, experimental, recreational, and chronic users and between different types of life problems associated with substance abuse among juvenile offenders. (Lightfoot, Lightfoot, and Hodgins, as cited in Lightfoot and Barbaree, (1993)). Part of individual treatment planning should be determining the interventions that are appropriate for each type of substance abuse problem as well as it's correlation to the sexually abusive behavior.

Even the wards know that substance abuse intervention is important. Listen to the words of two different wards, "I needs a drug program but no beds are available", and" I can't do no good on the drug program because I can't read".

D. Deviant Sexual Interests: In their sample of 197 juvenile sex offenders, Schram, Milloy, and Rowe (1991) found that sexual recidivists, defined as juveniles arrested for a new offense, were significantly more likely than other offenders to have deviant patterns of sexual arousal. This is an issue that is most important for the CYA to address.

At this time The California Youth Authority has no way to assess a ward's degree of deviant arousal except for self-report. There is also no policy and procedure and no protocol for the reduction of deviant arousal if it is present. Individual therapists sometimes use acceptable arousal-reconditioning methods with a select few clients but this tends to be a result of the available time as well which psychologists have training in this area.

Recommendation: The CYA should identify a protocol for assessing sexual interest and for intervening in interrupting that arousal pattern. When sexual arousal is present, its control or management is a priority. The Sex Offender Work Plan makes some suggestions about how to do this and these will receive comments in Question Six.

G. Therapeutic Community or Culture: Placement in a sex offense specific residential setting means two things: an individual poses an unacceptable risk to others and to themselves in the community, and successful rehabilitation will require the temporary restructuring of his/her world experience from the ground up. In other words, in order to be effective, residential treatment must be more than outpatient treatment in a socially controlled and isolated facility. The total treatment environment must be an integration of all of the components so that for twenty-four hours a day there is constant opportunities to apply therapeutic interventions and newly learned skills.

For this reason, the standard of practice for residential programs is the development of a therapeutic community, sometimes called a therapeutic milieu or an abuse specific milieu. This kind of community is carefully designed to support positive, prosocial behavior, and to decrease negative, antisocial behavior. In the case of sexual offending, this also means to support non-offending behavior and to confront offending behavior.

In offense specific treatment everything in the environment must be designed to alter and change those characteristics that support offending behavior and encourage those characteristics that are necessary for non-offending behavior. This offense specific approach means that treatment takes place continuously on a 24/7 basis – thus the impact of the therapeutic community.

> "...It is essential that staff, administrators, and members of the governing authority understand that the special needs of sexually abusive/ aggressive youth must be addressed 24 hours a day, 7 days a week. This means that the total environment of any residential program is offense-specific. The ways in which the residents interact daily with others, relate to authority figures, and deal with their feelings present opportunities for staff to address abusive dynamics in the context of daily living."
>
> *Standard 22, "Standards of Care for Youth in Sex Offense Specific Residential Programs" (1998)*

The CYA, instead of developing a therapeutic culture, has allowed a counter-productive prison culture to develop. This culture is reactive rather than proactive, and punitive rather than educational. In some cases it has become an us against them culture. It is a culture that doesn't allow adolescents to act like adolescents but treats what for most parents is simply annoying, irritating, obnoxious teenage developmental behavior as criminal behavior.

Recommendation: The CYA should continue to move as rapidly as possible toward a treatment or rehabilitation model and plan opportunities for rehabilitation 24/7. This has many advantages, just one of them a decrease in treatment time and increase in treatment effectiveness. Minnesota has mandated this:

Chapter 2955 of the Minnesota rules, Minnesota Department of Corrections is as follows: 2955.0020 subpart 31 Therapeutic Milieu. "Therapeutic milieu means the planned and controlled use of the program environment and components as part of the treatment regiment to foster and support desired behavioral and cognitive changes in clients. A

therapeutic milieu functions to coordinate and integrate supervised group living and the delivery of treatment services with other program components such as security, medical and psychiatric care, social services, nutrition, education, recreation, and spirituality. The nature and degree of development of a therapeutic milieu in the program may vary, depending upon the certificate holder's basic treatment protocol and the environmental and other conciliations in which the program operates."

H. Psycho educational Groups: Psycho educational groups about the issues typical for sexually abusive youth – anger management, impulse control, life coping skills, healthy sexuality, etc – are being offered but usually it depends on staff being available or staff being trained. The materials are copied from a wide variety of materials copied by program staff that are all appropriate but that are not offered in any consistent materials.

I. Behavior Management within a Therapeutic Milieu: Residential treatment must begin by providing a safe environment. This is necessary before any treatment takes place and is an essential part of treatment as well. It is well known that the relationship within which behavior management takes place is critical to its effectiveness with adolescents. When youth use aggression, manipulation, power, or control it is usually a defense mechanism in order to establish their invulnerability and maintain safety or perhaps in some cases – typical adolescent developmental behavior. Through relationships adolescents learn to modify their view of the world as unsafe and unfair, learn to tolerate closeness, experience compassion and empathy (which must happen before they can demonstrate it to others), learn self discipline, values, and responsibility, learn to give and take, and to practice pro-social values.

There are individuals who see this kind of approach as a soft one. Anyone who chooses to act out of an internalized value system rather than react to the circumstances around them knows that this is not true. Self discipline is the toughest kind of discipline. Rules, structure and consequences are certainly important, however, unsocialized youth become socialized through relationships. The end result is self-discipline, which is really the only effective kind.

Effective behavior management is based on discipline. Punishment is typically what a frustrated adult does to an adolescent to decrease the adult's feeling of frustration. It is rarely effective as a means of instilling values or lasting change. Discipline, on the other hand, is often direct feedback from the environment that signals to the youth that his choice was a bad one and that this approach will keep him or her in prison environments. Anyone who has ever received a speeding ticket understands what consequences and discipline are all about, as well as the fact that the close supervision of the officer was necessary for speeding to be detected. The attitude of the officer as well as the logical consequences imposed effects our acceptance of this corrective action...

Behavioral interventions are opportunities for teaching to take place. Many young people even prefer punishment to discipline because it is over and done with quickly and is less

painful than what it takes to learn to do differently. As one guard reported, "the wards prefer to be maced, it's painful for a little while and then it's over and done with." Or as another said, "I like to be maced, it feels good to hurt", and another, "I like to see if I can push them so hard that they will lose it."

Some of the behavior management strategies being used at this time are not conducive to changing behavior but are even counter productive for a sex offender program. For example, it makes little sense to utilize room restriction or isolation as a consequence for individuals who prefer to withdraw and avoid personal interactions. In fact, room restriction or any other kind of isolation allows sex offenders opportunities to fantasize about deviant sexual behavior and make plans for that behavior. The fact is that sex offenders need to be kept very busy, not stagnant.

Currently there is a sharp division between security and treatment services. This is often the case when juvenile facilities are organized after an adult correctional model. In juvenile facilities organized this way, a significant number of the adults are designated as "security" or "correctional" officers whose responsibilities are often limited to giving orders and enforcing them through disciplinary sanctions, threats and physical force. Although these are the adults with whom the juveniles spend the most time, they often do not, and are not expected, to be involved in the rehabilitative treatment of the juvenile. Instead, other professionals provide rehabilitative treatment in discrete doses in much the same way medical treatment is dispensed.

Such tactics are especially prone to abuse when staff is not adequately trained in the differences between adult and adolescent behavior. We know that juveniles, more than adults, are prone to defiance and disobedience that can be addressed through verbal interventions. But officers trained in adult prison practices, or who come from a background of adult corrections, use rational correctional responses and don't get the desired results. When this happens then they just use the traditional methods more so. When staff are not trained to work with adolescents or not supervised closely enough, they can respond to non compliant adolescent behavior as if it were criminal behavior. When obnoxious, irritating and rebellious adolescent behavior is responded to with threats and force, and minor incidents get escalated.

The security staff, not trained in the processes for dealing with adolescents, Also know little or nothing about the treatment needs or plans for the juveniles under their watch, and they are unable to take advantage of the numerous daily opportunities presented for confronting maladaptive adolescent behaviors in a way that transforms instances of conflict into opportunities for self-reflection and learning. The use of extended isolation as a method of behavior control, for example, is an import from the adult system that has proven both harmful and counterproductive when applied to juveniles. It too often leads to increased incidents of depression and self-mutilation among isolated juveniles, while also exacerbates their behavior problems. Research has shown that the use of prolonged isolation leads to increase not decreased, acting out, particularly among juveniles with mental illness. For sex offenders it is one of the high-

risk behaviors that they must avoid. It is boredom that is sometimes a precursor of the deviant fantasies that lead to sexual behavior.

Mace is one of the current methods of behavior control. Although the intent is to use mace when a ward is a threat to self or others (and I question its use even here), mace is resorted to quickly in many other situations. The following information comes from documentation, interviews with staff and wards:

> Mace was used for these reasons: refusing to follow instructions, distracting staff in the performance of their duties, masturbating so that female staff would see, kicking their door, refusing to follow directions, etc. Many of the staff likes the use of mace – it's quick and easy. One ward even reported the following: "I like to be maced cause I like to feel pain. Once my mouth and eye burned for a long time afterward."
>
> Threatened with mace: ward with acne cream was told to drop cream to the floor or be maced.

Behavior management reports for made for the following: holding hands with another ward refusing to go to school, profanity, racial slurs, being disruptive, passing items, refusal to go to school, not bringing laundry out at the assigned time, not keeping silence, looking in a room after being told not to, to name a few. On one occasion a ward was written up for failing to attend a class that she told the staff that she did not have. She appealed this ruling and appeal was granted.

The above situations are either treatment issues or typical adolescent behavior. These situations are opportunities to teach wards new and more functional ways of behavior. Of course, teaching doesn't mean that discipline or consequences do not take place as these two go hand in hand. As one staff member said, "Lots of misunderstandings between wards and staff lead to arguments. If staff were properly trained they would know how to avoid those." There is no reason to argue if your purpose is to teach.

It is counter therapeutic to use authoritarian or abusive language or behavior with sexually abusive youth. We are trying to teach wards to be non abusive – how to change their abusive behaviors. They are familiar with abuse. As one ward at Preston reported – "the staff doesn't respect you unless they are scared of you so I just make sure that they are scared of me." And another at Carter, "they are first prison guards and then treatment staff".

Recommendation: The CYA should take positive and proactive steps to change from an institutional and punitive model to a teaching and rehabilitative model. In a teaching model, all staff are teachers and role models. Institutions lock children in at night and they don't supervise them. Institutions have a minimum of staff and a maximum of children. Institutions warehouse young people in a sterile environment, which depersonalizes and dehumanizes them, and at best will teach them to behave - while in the program. At the worst it encourages rebellion and teaches anti social

behavior. What institutions don't do is provide remotely effective treatment or adequate supervision for a population as complex and unique as sexually abusive and/or offending youth. There is no opportunity to change, or to learn how to develop healthy and normal relationships when incarcerated in an institution with an institutional mentality.

The CYA is not unaware of the need to be rehabilitative rather than punitive. In fact they are making active efforts to change that culture. However, on many occasions staff told of the difficulties in trying to carry this out. One cautionary and very strong memo bears this out:

> "Because it can utterly destroy the program, even slight abuse of an inmate, verbal or physical will not be tolerated. Our purpose is to foster respect, not fear. We will structure everything we say so as to generate a perception of fairness, purpose and respect. We can permit no profanity directed towards inmates. We will not be able to teach self-control, respect, courtesy, and good manners if we fail to demonstrate these qualities ourselves."(See also the CYA's Standard Operating Procedure Manual for the LEAD program's staff, who is called TAC officers (For Teach, Advise, and Counsel)).

I. Systems Integration: The Importance of All of the Expert Reports in Reference to Sexually Offending Programs: Normally the areas of behavior management, education, mental health, and vocational training, would be thoroughly covered in a sex offender specific evaluation. These areas are always integrated into the program design in such a way that they support the offense specific treatment issues. However, as other experts were assessing these areas, then their findings can be factored into the assessment of the sex offender program. With that in mind, those areas will be covered in relationship to their impact on sex offender specific treatment and the other reports will answer the questions of overall adequacy. Are these areas supportive or non-supportive of sex offender treatment or not, is the question to be answered.

Currently the interventions utilized for behavioral management, educational, mental health, medical, vocational, and substance abuse issues are considered as separate and distinct from sex offender specific treatment, and are not treated as an integral part of those treatment programs. Failing to understand the importance of a cohesive, collaborative therapeutic milieu, education, mental health; medical and vocational programs are not considered components of a sex offender treatment program, but parallel, separate services. The integration of all of these components into sex offender treatment is essential, and the reasons are logical. Sexually abusive behavior does not happen in isolation, it happens within a personal and social context. So, too is teaching an offender how to change, though this job is harder. Therefore the importance of taking advantage of all the interwoven aspects of a juvenile's life and learning.

Despite its complexity, an effective juvenile sexual offender treatment program in which all parts are integrated costs no more to implement and run compared to what it saves, within as well as without the prison walls. Taken overall, poorly designed treatment programs are a constant and ongoing drain on financial resources. Also, some ill

conceived treatment programs even have the possibility of strengthening deviant behavioral habits and mental patterns (and thereby increase the costs associated with more problematic offenders).

Recommendation: The CYA should design programs to be comprehensive by integrate all components of a program into a cohesive model.

- **Educational System:** The impact of the educational system on the sex offender program been is not being considered. The teachers are not trained in working with sexually abusive youth, and so do not know how to confront abusive behavior, redirect sexualized behavior, or to keep their classrooms safe. They do not have any part in their treatment planning and are not kept informed about the progress or lack of progress of the youth in treatment. As a result treatment staff misses valuable input and educational staff misses being informed about interventions that would be helpful in the classroom. In some programs a personal relationship has developed between the members of the sex offender treatment team and the educational staff. In other cases sexual harassment has been a frequent occurrence. Although I did not see this myself, I was told by facility staff that some wards are so dangerous that they are put in cages in the classroom. The turnover in the educational staff is high. The integration of the educational programs and specially trained educators are not just options; they are basic components of successful juvenile sex offender treatment programs. Although there are extra short term costs ere, they are investments which soon pay for themselves in literal, observable, even sometimes quantifiable ways. Short term knee jerk reactions do not.

There are several reasons why the role of education is so important. First, we have extensive information about the special educational deficits of sexually abusive youth. Research on juvenile delinquents by Ferrara and McDonald (1996) has noted two areas of impairment with sexual offenders: difficulties with executive functions, such as planning, abstraction, inhibition of inappropriate impulses, and cognitive flexibility; and difficulties with receptive and expressive language. A review of the literature leads them also to conclude that between one-quarter and one-third of juvenile sex offenders might have some form of neurological impairment. To quote: "Furthermore, it is likely that the neurologically impaired juvenile sex offender who goes undetected will not attain the [optimal] benefit from treatment due to problems in concentration, comprehension, and memory"

In addition we know the following about juvenile sex offenders and their educational needs:

- Kahn and Chambers found that more than half of the juveniles in their study of sexually abusive youth had evidenced at least one of three kinds of difficulty at school: disruptive behavior (53 percent), truancy (nearly 30 percent), or a learning disability (39 percent).

- As part of an investigation of learning difficulties as a potential factor in sex offender treatment, Langevin, Marentette, and Rosati (1996) found that 53 percent of the subjects apparently experienced learning difficulties during childhood. 38

percent had been placed in special classes, and 14 percent were diagnosed as mentally retarded.

- Intellectual and cognitive impairments are very important factors that should be addressed in sex offender treatment. (Awad, Saunders, and Levene, as cited in Knight and Prentky, 1993; McCurry et al., (1998)).

- Violent juvenile sex offenders tended to have lower IQ scores than nonviolent sex offenders, which raise the question if this could be attributed to higher rates of neurological impairments among violent offenders. Saunders et al. (as cited in Ferrara and McDonald, (1996)).

- Verbal deficits were associated with higher rates of aggression and antisocial behavior for juveniles who fell within the normal range of intelligence. Deficits in verbal cognitive functioning, reflected by impulsivity and poor judgment, might contribute to the increased rates of serious inappropriate sexual behaviors among these juveniles. (McCurry et al.(1998)).

- A closer examination, based on normative data, revealed that more than expected fell within the borderline range of intellectual functioning (i.e., IQ of 70-79), fewer than expected were within the "bright normal" range (IQ of 110-119), and more than expected fell within the very superior range (i.e., IQ of 130-140).

Second, the most sexually abusive behavior is part of a cycle of behavior that may take place within a couple of hours or a couple of months or longer. This cycle does not happen in a vacuum. The cycle is part of the wards daily existence. The opportunity to intervene, and redirect that cycle happens throughout the day – not just when the wards are out of school. Sexually abusive behavior issues must be addressed on a 24/7 basis. Experience has taught us that sexually abusive youth will act out in places where they are most likely not to be detected – and school can be one of these places if it is not part of the intervention program and if the staff is not well trained to handle this. This can put other youth as well as teachers at risk

Third, it is important for the safety of both the teaching staff and the wards that the educational staff and the educational system know how to handle sexual behaviors and issues. Instances of sexual harassment often occur in the classroom where teachers are not trained to intervene. In addition, the possibility of real boundary issues occurs when adults do not understand interpersonal relationships with sexual offenders as well as the dynamics of sexual offender's behavior.

In addition, wards are in the classroom for a significant part of the day and teachers are very influential. For this reason it is necessary that the school personnel be trained in working with sexually abusive youth and be an active part of the multidisciplinary treatment team in treatment planning. This means that teachers are trained in working with this population, know how to respond to them, know what their special needs are and participate fully in treatment planning. This is difficult to do when the teaching staff

has to try to focus on a number of youth with a variety of problems and do not have the training and skills to intervene with one very special population.

And finally, an important aspect of the teachers work with sexually abusive youth is to prepare them to return to public schools. All the reasons why it is unsafe and destructive to treatment to send juvenile sexual offenders into general public school populations before they are ready are enormously magnified when the general school population is also a general prison population. Particularly a general prison population likes that of most CYA facilities, which are increasingly dominated by juveniles with violent and/ or gang related behavior. Until the resident has progressed to a certain point in his treatment and is mentally and behaviorally prepared for a mainstream educational environment, however, the youth should be educated within the facility by teachers with sex-offender specific training who work closely with the treatment team.

Recommendation: The CYA should involve the educational staff in sex offender specific treatment and provide them with offense specific training. Juvenile sex offenders with learning disabilities must be provided special education services to enable them to benefit from educational services, juveniles with cognitive disabilities may require special assistance to benefit from substance abuse programming, youths with severe attention deficit disorder may require accommodations in facility rules to prevent their disability from resulting in disciplinary sanctions. Without this it is likely that active participation is a program for sexually abusive wards will be difficult.

- **Vocational Training:** The Youth Authority has some excellent vocational programs. I particularly enjoyed the benefits of the culinary program at Preston, the grounds program at other institutions and was very impressed when learning about the fire brigade program. Unfortunately these programs are not open to sex offenders except for rare exceptions. This is unfortunate, as part of long-term success with these wards will depend on whether or not they have the skills to support themselves in the real world. Besides being able to support themselves, a secondary gain of having vocational skills is the self-esteem that is developed as a result. This was obvious in the faces of the youth I saw involved in work programs and in the enthusiasm about them.

Recommendation: The CYA should make sure that all wards in the sex offender programs have some kind of vocational training that increases in complexity, as the wards grow older.

- **Medical Issues:** There are two reasons why attention to the medical program is important for sexually abusive youth. First, there is data that suggests that juvenile sex offenders have many physical complaints, some of them somatic in nature and some of them real. Part of treatment is learning to differentiate between what is a real medical complaint and what is somatic in origin so that they can be dealt with in different ways. Somatic complaints, for example, are very common in victims of abuse and are a way of externalizing pain. There is also no doubt that one cannot participate in any program

when one is in real or imagined physical pain or when one has a physical deficits that keeps one from doing so.

Secondly, co occurring disorders are not uncommon with sex offenders. If these are accurately diagnosed and assessed it is possible that the prescription of medication will give wards the opportunity to respond to the sex offender program. For wards with severe ADHD, impulsivity and depression – to name a few disorders - it is not often not possible to do this without medication.

Recommendation: The CYA should consult with some of the medical experts who work with sexually abusive youth to develop a medical protocol that takes the specific needs of sexually abusive youth into consideration.

- **Mental Health:** "When viewed in the context of the whole life experience and functioning, sexually abusive behavior is often present in combination with other emotional, psychiatric, and or behavior dysfunctions and have important implications in the treatment of juveniles who are sexually abusive. Some of these co existing disorders may even impede the juvenile's ability to successfully participate and progress in offense specific treatment and may require stabilization before entry into an offense specific program." (The National Task Force Report, (1993))

Here's what we know about sexually abusive youth and mental health problems:

- Sexually aggressive youth who were placed in residential treatment centers had higher rates of "emotional disturbance" than youth in general who were placed in residential treatment centers (Becker, (1996)).
- When compared with age matched control group of youth in residential treatment for other problems sexually abusive youth had higher rates of hyperactivity or restlessness, depression and anxiety, fire setting, encopresis, running away, early onset of neurological conditions or illness, learning disorders and health problems (Bagley and Schewchuk-Dann, (1991)).
- Adolescents who sexually offend against younger children evidenced higher scored on the? Schizoid, Avoidant, and Depaent scales of the MCMI than those who offended against peers. Narcissism was significant in those that offended against peers (Carpenter, Peed, and Eastman (1996)).
- Mental health co occurring disorders over represented are substance abuse, ADHD, PTSD, OCD, affective disorders and learning disabilities (Ryan and Lane, (1997), Miner, Siekert, and Ackland, (1997)).

Whatever the particular numbers, there is no reason to believe that there are fewer sexually abusive youth with mental health problems in the Califonia Youth Authority than in the other correctional or residential systems. It is clear from research data that a sizeable portion of youths with sexually abusive behaviors have significant mental health needs. These youth may not be able to access offense specific treatment for just this reason.

Far too often, inadequately trained staff does not see that disobedience, defiance or even threats can be an offshoot of mental illness. Staff responds with anger, discipline or even force -- even though other interventions could have defused the situation. In these kinds of circumstances, it is not helpful to punish a juvenile for behavior caused by mental illness. And it is not helpful to expect correctional officers to supervise juveniles who are mentally ill in appropriate ways if they have not been trained how to do so.

Moreover, once a mental health need has been identified, it is not enough simply to have a psychiatrist who rarely visits the facility prescribe psychotropic medications. Professionals must be involved in providing individualized treatment and in considering what reasonable accommodations are necessary to permit the juvenile to benefit from the services offered at the facility. And, when adequate mental health care cannot be provided at the facility, the system should provide alternative placements where it can be provided.

Quote from a staff member: "Probably 90% of the sex offenders in the CYA have a diagnosable disorder. It would be better and less risk to deal with kids with co morbid issues in one program" While this may be an exaggeration, the concept is certainly valid.

Recommendation: The absence of adequate mental health services to the wards of the California youth Authority has been the subject of several other audits. The results of those audits were recommendations that would change that situation. The CYA should take into consideration the particular meaning that this has for the sexually abusive wards and enter into consultation with those who are specialist at co occurring disorders with juvenile sex offenders.

3. Discharge/Aftercare Planning

A. Discharge planning: Offense specific programs must have discharge criteria that are based on the accomplishment of specific, measurable, objective, observable changes, and on the client's demonstrated ability to apply these changes to real life situations. Research studies indicate that the clinical judgment of professionals is not the best method for identifying discharge readiness or treatment success and for these reason objective measures of change are necessary. Completing program modules or workbooks is simply not adequate.

The California Youth Authority does not have a protocol for discharge planning. Discharge is currently based on wards responsiveness to the program, completion of paperwork, reports of their behavior on the unit, and clinical judgment. These are a part but not the entirety of appropriately determining discharge readiness. According to staff reports the extension of time can be based on a ward's personality or adolescent behavior patterns rather than his criminal risk factors

Recommendation: The CYA should develop a discharge protocol that is based on the accomplishment of specific and measurable, objective, observable changes and on the ward's demonstrated ability to apply these changes to real life situations.

B. Aftercare: "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 the initial assessment and treatment. It is the part of treatment that most directly connects with the juvenile's future" (National Adolescent Perpetrator Task Force Report, 1993)).

Research indicates that the post-discharge environment is a powerful factor in determining the successful long-term adjustment of individuals who have completed secure residential treatment programs.

There are four primary reasons that aftercare is a significant part of the treatment process: First, it encourages the individual to continue to use the tools he or she has learned to prevent sexually abusive behavior and focuses on strengthening continued behavior management. Second, it provides a clear-cut method for monitoring the individual's behavior after discharge. Third, it helps the individual transfer therapeutic gains to the community setting while providing continued support and monitoring through a multi-systems model of agency cooperation and collaboration. Finally, and most importantly, it provides the support of an individualized and personal support system, generally referred to in the fields involved as a circle of support, a containment team, or a relapse prevention team.

The standards adopted by the State of Virginia, for example, include the following statement on aftercare:

> "The majority of juveniles who complete sex offender treatment at a juvenile corrections center will require additional community based treatment. Community based treatment will allow the juvenile the opportunity to continue addressing issues identified at the JCC, as well as provides a supportive transition into the community."

The CYA does coordinate offense specific aftercare services with some county parole offices. Some of these county parole offices even have officers trained in working with sexually abusive juvenile males, and will arrange for treatment services to continue while a youth is on parole, making it a parole condition. If this were mandated for every identified sex offender ward upon discharge, it would serve as a very good aftercare model.

Recommendation: The CYA should develop an even closer affiliation with probation/parole departments, so that the transition to the community can be easier and safer. This would involve both collaboration and sharing of resources with every parole office in California.

2. Question Two: Does the California Youth Authority Have an Adequate Level of Training to Implement its Sex Offender Treatment Programs?

These questions must be divided into three sections in order to be answered. First, are appropriate staff hired, second, are the staff hired amendable to training and finally are they currently receiving the optimal training for the job.

A. Are the appropriate staff hired, and are staff hired amenable to training?

Before discussing staff training itself, one must first address whether staff currently and in the past have been hired who possess, both personally and professionally, the qualities and characteristics recommended for those working in this complex and specialized field. Even intensive training will not produce all of those personal characteristics that can have a positive effect on treatment, or decrease those which will have a negative impact.

There is ample research and professional literature that informs us of the importance of the therapeutic relationship and its influence on both safety and the success of treatment (Lambert (1991); The NCYFCJ National Task Force Report (1993); National Sex Offense Specific Standards for Residential Settings (1998); Blanchard, (1998); Marshall, et al (2001); etc.).

The importance of these kinds of staff considerations is not news to the CYA, either at the management or the program level. During this review there were many comments made about the fact that some staff were not interested in working with sexually abusive wards but were working in the program because they wanted a particular shift. In the current system, in a plan negotiated by their union, a certain percentage of staff has to be hired because they have seniority and get to bid for positions. This method of hiring gives first choice to people regardless of their qualifications- or lack of qualifications- to perform in a highly specialized program. This is not to say that all of the staff hired under the post and bid system are not qualified to do the work, or that all of the staff hired outside this system are qualified. However, staffing is a critical element of juvenile sex offender treatment, and the CYA needs to create and install hiring policies which are directed exclusively by industry certified staffing methods and the qualifications of applicants. The union certainly has the right to promote job benefits for its members but not at the expense of ward or public safety. When the post and bid decision was made, it is possible that the union simply did not know the importance of the kind of staff required for work with sexually abusive youth.

Lack of the personal characteristics and qualifications to work with a sexually abusive population reflects in no way upon a person's overall quality or accomplishment with other populations. Working with juvenile sexual offenders requires very specific

characteristics, strengths, and types of experience. Some mental health professionals who work well with other juvenile populations are nevertheless unsuited to this field.

In a residential program everyone has a therapeutic influence on the individual's change process - direct care staff, guards and clinicians. Although the therapist may be the major guide, all of the staff working as a team is integral to effective treatment. At one of the CYA institutions a ward said, "I've been here a year and only started to change in the last two months." When asked what happened to bring about this change, he pointed to a youth counselor and said, "He's never given up on me". This particular youth counselor had been with CYA for 14 years, and he possessed the very attributes we are discussing here. Some of those attributes are: the ability to control without being controlling; a non sexist attitude and healthy sexual values; an ability to set limits and follow through on consequences; an ability to use authority without abusing it; an ability to be comfortable with one's own sexuality; to be comfortable talking to youth about sexual issues; and to be able to work on changing sexually deviant behavior; the ability to be trustworthy; to teach; to have a good sense of humor; to set good boundaries; to role model; an ability to reject the behavior while caring for the person, an ability to withstand manipulation; an ability to be fair; etc. This is certainly not the whole list but will give you an idea of what we are talking about.

It is not surprising that personal characteristics are so important, since staff dominate a ward's psychological, social and physical environment. As a result, anything a ward observes or experiences of them consequently becomes a part of the treatment environment and process. People in general and young people in particular are more interested in what you do than what you say. What's more, they will automatically tend to judge the worth of what you say by what you do. Just as in life outside the prison, only more so, wards will consider all staff's behavior, not just their formal interactions with them. As a group sexually abusive youth are master social observers. If staff is not models of treatment's formal words and procedures the entire time they are on-site, the program's authority and the residents' motivation to internalize treatment concepts are significantly weakened.

As group juvenile sex offenders are also master's at spotting weaknesses, analyzing vulnerabilities, and manipulating others to satisfy themselves. As the most important people in a resident's social environment, the one's controlling all his needs, desires, and satisfactions, staff will be the people a juvenile sex offender is most interested in observing, understanding, and manipulating. In many institutions in the past I have observed staff being manipulated by juveniles who were unaware of the fact, and also would have been deeply offended by the suggestion that they could be manipulated in any fashion by such youth.

Being a member of a sex offender specific treatment program's staff means accepting that anything you do which is observable by anyone else on-site must model the objectives of the treatment program. Whether interacting with residents or other staff, or simply going about daily duties, staff must be aware of what kind of coping skills, attitudes, anger management, etcetera, they are displaying. It requires specific personal

characteristics to accomplish this in a juvenile sex offender treatment environment.

During an interview with a ward in the Oaks program I asked a ward if he thought the staff on the Oaks was qualified to work with a sex offender population. He replied, "Right now, there is only one that isn't. However, I haven't given up on her yet." When I shared this comment with staff at the facility they immediately knew exactly who the ward was referring to, and said that a lot of effort had been put into attempting to counsel them. Unfortunately, they also said that the unsuitable staff member was not amenable to change and that parties and policies outside the program were making it difficult to remove this person from the program. This is an unacceptable situation.

> "In view of the individual needs and developmental histories of juvenile the "quasi–corrections model" taken from the adult approach is not enough. In some programs staff seem to replicate the juvenile's power and control behaviors and secretive behavior in the staff's own interactions among themselves and in their interactions with the institutions managers, with other units and with the juveniles. The recommendation is that the staff in such programs for juveniles should either be chosen or trained to enable them to serve as appropriate role models." (Goocher, (1998))

Recommendation: The CYA should develop a protocol for hiring staff that takes into consideration both the personal and professional qualities necessary to work with a sexually abusive population. Any personnel responsible for staffing must themselves receive specific training both in identifying potential staff with the optimal personal characteristics, and in identifying those individuals who have the potential to be sexually, physically or emotionally abusive. This training is readily available, and interviewing techniques and the positive and negative characteristics to look for can be found in the professional literature and published research. After hiring has been accomplished, then training and close supervision will maintain the level of emotional and professional competency needed by all who interact with juvenile sex offender wards.

B. Staff Training: After conducting numerous staff interviews and searching for training manuals, plans, schedules or any other kind of documentation, I couldn't find any evidence that there was regular and mandated offense specific training for staff. I did not review the records of any other kind of training considered necessary for each job description.

The almost total lack of offense specific training was one of the most common complaints heard, and they came from newcomers and staff who had worked in the CYA for many years, alike. One individual, who had worked on the CYA sex offender program for four and a half years, said that he had received no pre-placement training and a total of only six days of offense specific training since he was hired. Another commented, "I would like to stay with the department but there is not enough training

and not enough programs... the program really works when they have the time to put it in place"

In fact, the lack of offense specific training was so obvious that even some of the wards commented on it. A ward at Humboldt said, "Most staff doesn't have any formal training. I hear them complaining about it all the time." A second said, "Youth counselors just aren't treatment-sharp". A group of eight youth interviewed at the Carter program all spoke of the fact that they were in group one hour a week – when it wasn't cancelled due to various crises. They did have treatment-related homework to do, but only a few of the staff had any understanding of the assignments so more often than not there was no one to ask for any help.

Reviewing documentation in the wards' charts in all programs, I found instances where the staff missed cues or made judgment calls that could be contributed to lack of training and lack of supervision. For example, someone had filled out a SORD that indicated the ward was a high-risk sex offender. Reviewing the chart I could find no evidence that this was accurate. The psychologist asked to also review the chart agreed. The conclusion was that although this staff (the one who filled out the SORD) was very competent in general that they did not know how to accurately fill out the SORD. This kind of mistake could result in years of a ward being designated a high-risk sex offender who actually had no history of being a sex offender at all.

The difficulty and complexity of working with this population, the relative newness of the discipline (20 years), and the number of dual diagnosis wards requires that staff receive regular training provided according to a formal and continually updated and documented training plan. Such training plans also provide the program as a whole with important accountability measures for any licensing or accreditation that may be sought, and for any litigation that might be faced. Everyone who has responsibility for the program or who will interact with the wards needs offense specific training in direct proportion to that person's interaction with the wards.

The time and resources spent on training are extremely cost-effective. They pay off in much safer, more efficient and effective programs. One of the issues that impacts strongly on staff morale and turnover, as well as upon the efficiency and efficacy of a program, is inadequate training for working with the treatment population a staff is expected to serve. By enhancing job satisfaction for staff, rates of burnout and turnover are lowered, stabilizing and improving the operation of the program, and reducing operational costs to the State. The most efficient programs are also the most successful programs, reducing recidivism and therefore the financial and emotional costs to the public of reoffending.

Many States, including Indiana, Utah, Ohio, Minnesota, Oregon and Washington, have mandated sex offender treatment standards or established guidelines for sex offender therapist qualifications which include on-going training requirements. In some instances therapists are required to be credentialed or certified in order to offer clinical services. In other instances a certain number of training hours are required for all staff working in a

program. The state of Arkansas, for example, requires that all staff that work directly with this population have proof of completion of a professional certification program. Other states such as Kentucky and Ohio have developed two-week academic courses.

Recommendation: The CYA should develop a mandated and comprehensive offense specific training program for all staff that includes detailed curricula for pre-employment and in-service training. The program should include a monitoring system and a system for measuring the transfer of knowledge, as well as plans of correction for those people who do not complete the training or who do not pass the transfer of knowledge examination. There is even a number of pre-existing training programs available that could be used as guidelines. The CYA should also develop a professional lending library at the central offices with current and updated professional resources that institutions could share as needed.

3. Question Three: Does the CYA Have the Level of Staffing Needed?

Staffing levels at the CYA are not adequate for a population that requires high levels of interaction and close supervision as part of the treatment program. The CYA and staff are more than aware of the shortages and the reasons for the need for more (appropriate) staff:

> "Some wards just can't get it, and some are so disruptive that they interfere with the program. There are kids here from 14 to 25 and many different kinds of kids – some need individual treatment, some need group, some need structure, some can self structure."

Here is an example of the staffing protocol for other state correctional facilities:

- Minnesota has mandatory rules for the amount of staffing necessary in different levels of programs. For example a category one program is required to provide at least one full time sex offender therapist counselor per eight clients but no less than one therapist per 16 clients. The ratio of direct service staff to clients during waking hours is 1 to 12; during non-waking hours there must be one present awake alert for every 24 individuals and a combination of staff resources to support that person.

Recommendation: The CYA should compare its ratio of staffing levels to other correctional systems who serve this population. The standard of care is that the staffing level is dependent on the acuity level of the individuals served, the competency of the staff, the number of years of employment, the environmental configuration of the unit, the job responsibilities of the staff, the program design and delivery requirements and anything else that should be pertinent at any given moment.

4. Question Four: Does CYA have Appropriate Policies and Procedures Concerning the Provision of Sex Offender Treatment?

At this time there is no policy and procedure manual for sex offender treatment. There are only two policies that do apply to sex offenders – one is about the Sex Offender Referral Document and the other is about the legislative mandate to treat certain sex offenders. The sex offender work group has developed a sex offender program design and the next step would be to develop policies and procedures for the implantation and delivery of that model.

Recommendation: The Sex Offender Work group along with the Central Office Coordinator should continue to work together to develop a complete policy and procedure manual along with an implantation process. In some states law, along with licensure by the state and an oversight committee, mandates the policies and procedures for sex offender programs and I would recommend this for all states.

The Virginia Department of Juvenile Justice has a Sex Offender Services Procedure Manual which was developed by the Treatment of Adolescent Sexual Offenders Committee, a committee whose 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 in Virginia.

5. Question Five: Thoughts and Recommendations on the CYA's Transition from a Program Model to a Case Management Model – Vision and Implementation.

A program model is much more suited to juvenile sex offenders than a case management model. Juvenile sex offender treatment depends on a strong peer group culture, a strong treatment team approach, a therapeutic environment, and very focused treatment. While case management may work for other populations – and I am not convinced of that – it will not work for this population or this kind of program.

6. Question Six: Thoughts and Recommendations on CYA's Sex Offender Treatment Work Group Proposals.

In October 2002, the CYA appointed a sex offender treatment work group and charged them with designing a sex offender program that would meet minimum standards of practice in the field. The temporary position of program coordinator was added to the central office staff to oversee and coordinate the project. The expectations were that the work group would accomplish the following goals:

- Standardize all sex offender treatment programs and curriculum in institutions and parole

- Standardize sex offender treatment modalities and determine the most appropriate treatment plans for various classifications of sex offenders
- Maximize sex offender treatment resources in institutions and parole
- Develop an outpatient sex offender program cubiculum
- Develop performance standards for sex offender treatment
- Review best practices nationwide in sex offender intake, classification and treatment modalities

In May of 2003 the plan was completed and approximately 300 individuals from the residential sex offender programs, the Intensive Counseling Programs, and the Specialized counseling programs were trained in an overview of the program and in the use of the Sex Offender Referral Document. Approximately 150 individuals received the training on the implementation of the work plan. These included superintendents, assistant superintendents, program administrators, parole agent one and three, supervising casework specialists, casework specialists, youth correctional counselors and psychologists.

In July a budget request proposal was submitted that would provide the funds to implement the plan in its entirety.

Reviewer Comments: The result of these efforts was the creation of a plan for sex offender programs that is a commendable work by a group of talented professionals. There are some weaknesses in the plan which will be reviewed along with the steps necessary to correct those deficits.

One of the problems that continue to face the CYA is the expectation that successful programs can be developed and implemented without the necessary funding to do so. When an organizational system lives in this kind of a culture, it will eventually affect everyone, albeit in different ways. These are some of the typical comments of the staff: "They ask us to be realistic about what is possible, are they saying hot water is unrealistic?" "There's no use asking for that, it just won't happen", "We have to make do with what we have", "we are just so beaten down and don't' expect anything to change"; "that used to be in the budget, but it's been cut"; we don't have the budget to fix the heating system". The pessimism is ingrained and seems entirely reasonable considering these experiences. Yet there are also those individuals that remain extremely determined, "We have to keep fighting for what is right because we are responsible for the rehabilitation of these kids and that's too important to give up on."

Recommendation: The CYA should keep the Coordinator of the Sex Offender Work Group and the Work Group functioning to develop policies and procedures, program components and evaluate the ongoing standard of the program against national standards. Funding to do this will be a necessity.

Components of the CYA Sex Offender Program Plan May 2003:

Sex Offender Treatment Program Coordinator: The Work Group Plan calls for a Sex Offender Treatment Program Coordinator, housed in the Central Office in the Institutions and Camps Mental Health unit. These are the responsibilities suggested for that position:

1. Oversee all movement to and from the Residential and Outpatient Sex Offender Programs.

2. Ensure that each Residential Sex Offender Treatment Program has an equal number of lower functioning wards, and will ensure that the ages and mental sophistication of the wards are appropriate to the particular services of the institutions to which they are directed.

3. Monitor the number of wards in the outpatient programs and attempt to equalize these numbers according to the institutions' available resources.

4. Monitor the consistency and quality of the Sex Offender Treatment Programs.

5. Assist the program staff in their efforts to continually improve the quality of sex offender treatment.

6. Plan and oversee the sex offender training (both departmental and outside/professional) for all staff in the sex offender programs.

7. Manage the portion of the training budget specific to sex offender treatment.

8. Monitor ongoing research with the Research Department for best practices.

Reviewers Comments: A person at the central office level is critical in order to develop, coordinate, and see to the implementation of this plan. Without this I doubt any plan can be accomplished.

Recommendation: The CYA should fund a permanent position at the Central Office to carry out the above job responsibilities as well as the other job responsibilities suggested by this reviewer. These additional responsibilities are:

1. Develop a comprehensive implementation plan that will guide the process of actualizing programs so that meet standards of care

2. Develop the additional program components recommended by this reviewer and oversee their implementation;

3. Develop a comprehensive training plan that identifies curricula for all sex offender specific training programs as well as a way to monitor its delivery. This would include identifying pre employment training, in service training, and a method for testing transfer of information;

4. Develop policies and procedures for offense specific staff supervision for all of the staffing levels

5. Develop and maintain a resource lending library at the central office that can be used by all of the sex offender programs

6. Identify culturally appropriate materials to use with specific cultures

7. Identify and utilize materials that are written specifically for the developmentally delayed

8. Develop a comprehensive family involvement program that meets current standards of practice

9. Develop plans for a therapeutic milieu, train staff in its implementation, and supervision

10. Identify and plan a gender specific sex offender program for the female wards of the CYA

11. Identify a hiring and screening method that will elicit those qualities both professional and personal that are optimal for working with a sexually abusive population.

- **Goal Statement**: The Sex Offender Work Group has identified the goals of the sex offender treatment programs as the following. "To provide treatment for all wards that are committed for a sex offense, have a prior adjudication/conviction of a sex offense, have a documented history of sex offenses have a reported or documented pattern of deviant or sexually inappropriate behavior (including some DDMS behaviors with a pattern)" (Program Overview, May 2003)

Reviewer Comments: This goal statement rectifies the unfortunate decision to treat only those sex offenders mandated treatment under WIC 727.6. This decision left approximately 600-800 wards in the California Youth Authority who would be released into the community having had no treatment at all. What's more, the definitions of who was considered to be a treatment priority did not effectively identify all of the highest risk sex offenders.

Recommendation: This is a very good decision and there are no recommendations.

Continuum of Care model: The proposed model contains provision for two levels of care – residential and outpatient. Aftercare, which is an important component of both levels, would take place through the parole system, but would be planned to be consistent with the institutional programs.

Reviewer Comments: This is a creative idea – that of providing both residential and outpatient treatment within the CYA system- and might be workable under some conditions. The outpatient program design was conceived to be as realistic as possible under the present conditions. Unfortunately while this idea may be cost effective for the Youth Authority, it is improbable that it will facilitate successful sex offender program completion. Although the intent to provide different levels of intervention is a good one, placement decisions cannot be made simply by dividing numbers the numbers evenly. Placement decisions cannot be made solely on the basis of the budget when those decisions will not facilitate rehabilitation.

It is true that The Youth Authority would be amenable to other levels of care, however. There are many different levels within a continuum of care and several different ways to develop them. For example, it is possible to develop all levels of a continuum of care within one State system, or to link services in a number of State systems. Correctional systems are not meant to include all levels along the continuum, but could provide some of them such as small community based residential centers, group homes, etc, and outpatient programs in addition to the standard secure institutional facilities.

I have grave concerns about providing outpatient programs in all of the institutions. Even if outpatient programs were developed, it probably would not be the treatment of choice for a majority of wards. If this plan were to be carried out, the decision of placement should be made only after a comprehensive assessment to determine if this is appropriate. A screening device simply does not provide adequate information to make that decision.

There are many logical reasons why this plan is concerning. The first is the well-known fact that child molesters and rapists have a difficult time in the general population. As one youth said to me, "in the general pop you gotta think about survival, not treatment". Another youth said, "Outpatient groups might work in a place like Ventura. I've been in several other institutions in the CYA and it wouldn't work in any of those places."

The second problem is one of logistics – of bringing youth to the group. Observation during site visits revealed that that there already appeared to be difficulty in getting the wards to planned activities on time. In Ventura, where the boys were brought to sex offender group in the main building the comment was made that the group was never consistent – sometimes there was no one to bring them over, sometimes the group got there so late that most of the allotted time was over.

The third concern involves the lack of a functioning therapeutic milieu, which is considered an important component of residential treatment with this particular population, and which would be totally absent in an outpatient program.

The final difficulty has to do with the intensity of the program. The outpatient program is designed to be 50% less intensive than the residential program yet there is no data that indicates that the youth expected to be assigned to the outpatient programs need 50% less intensive treatment.

Recommendation: Take another look at the decision to have the majority of the wards placed in outpatient treatment. Develop a profile of the wards that would be suitable for an outpatient program in a general prison population, and then make sure that only those wards which met this standard are admitted to those programs.

It is very likely that there is a need for more residential programs and fewer outpatient programs. As the plan indicates the wards in the outpatient programs would need to be highly motivated, and with good ego strength. I doubt that you can find approximately 500 or more highly motivated wards in the CYA. Sex offenders don't often come into treatment already highly motivated. This is typically one of the first challenges of treatment.

If the plan for outpatient programs were to be carried out, then a comprehensive, focused assessment must be the deciding factor of appropriateness for admission to that program.

Since there is an adequate amount of space and a large amount of numbers that need offense specific treatment, very serious consideration needs to be given to more residential programs.

- **Placement Decisions**: The SORD, which has been recently updated and improved, is the sole screening device for decision making regarding placement in residential or outpatient programs.

Reviewer Comments: It is the usual practice for a risk assessment (needs assessment, pre disposition assessment) to be conducted pre-sentencing, so that informed decisions can be made regarding placement. Risk assessments generally are composed of a number of tests, not just a single screening survey. Since it isn't the standard practice in California for there to be a pre-sentencing assessment, this results in wards being placed in the California Youth Authority that might be more appropriately, safely, and inexpensively served in the community in a less restrictive environment.

Recommendation: The lack of a pre-sentencing assessment creates a serious dilemma, though one with several possible solutions. The CYA could require such assessments prior to accepting a ward for admission, or the court could require them prior to sentencing. Other states have opted for the establishment of uniform policies and procedures by appointing a multidisciplinary, multi-agency task force to plan procedures for the identification, prosecution, placement and treatment of sexually abusive juveniles.

Some states have made these standards, others have produced them as guidelines, and still others label them protocols. All, however, serve the immediate purpose of providing a uniform structure for all of the agencies involved and concerned.

Another solution would be a CYA sex offender diagnostic center, staffed with professionals who have the special training necessary to conduct offense specific assessments. All assessments could take place in the diagnostic center prior to the ward being assigned to an institution. This would not only aid in the appropriate placement of the wards, but would provide the intensive assessments needed for their individualized treatment plan. A diagnostic center could support itself by contracting with private agencies to conduct offense specific assessments. It would not be difficult to develop a protocol for assessments, because there are already protocols available which meet standards of practice. . This is one of the areas where California has the ability to become a leader in the field

- **Treatment Approach:** "Residential treatment will use a core cognitive behavioral approach" (Program Overview, May 2003)

Reviewer Comments: The cognitive behavioral approach is used by 79% of the programs for juvenile sex offenders. (Safer Society Foundation Survey, 2001) In a position paper dated Nov. 6, 1996, The Association for the Treatment of Sexual Abusers states:"The core approach used in many programs is cognitive-behavioral, which utilizes a relapse prevention model. The goal of this approach is to enable the offender to understand their own behavior, take responsibility for and increase motivation to change that behavior as well learn the skills necessary to control their deviancy. With training in relapse prevention techniques, offenders learn to identify the chain of thoughts and behaviors that, if uninterrupted, could culminate in the commission of a sex offense. As part of learning their individual sexual assault cycle or chain, the offender also learns alternative non-harmful techniques to intervene and stop the progression of behaviors."

Recommendation: Even with the cognitive behavioral approach as core, there is always a need to individualize treatment to meet specific needs. Other approaches should be used as well, where called for by the treatment needs assessment. This is clearly within the expertise of the psychologists currently working in the CYA, and needs to be formal part of treatment planning.

- **Length of program:** Although the length of the program has been estimated for every phase and stage, the point is made that the program is competency based and not all will pass through at the same rate.

Reviewer Comments: The length estimated is typical for secure residential programs. However, being competency based means that the wards will move through the phases at different rates. This means that the program adapts treatment to meet the characteristics

of the ward, rather than forcing them into a theoretical time frame which doesn't effectively meet their actual treatment needs.

Recommendation: This is a good plan. In order for there to be no misunderstanding of the program's treatment objectives, the meaning of "competency based" needs to be formally defined in concrete terms.

- **Discharge Planning**: The plan calls for discharge to be competency based.

Reviewers Comments: Being competency based means that there are measurable concrete behavioral objectives that determine a ward's readiness for discharge. These will be clear to both the wards and the staff and hopefully will eliminate two problems about discharge. The first is the mistaken belief that finishing paperwork or time spent is the completion of a treatment program. The second is that discharge readiness cannot be determined by a staff belief or feelings about a ward's progression or lack of in treatment. Although clinical input is part of decision making and is important, it should not be all of it.

Recommendation: There are actually three different kinds of discharges possible in a sex offender program, and responses to each must be prepared and planned for by staff. The CYA should develop comprehensive policies and procedures for the following kinds of discharge:

- **Successful program completion**: This requires accomplishment of specific and measurable, objective, observable changes in behavioral, emotional, attitudinal, social, cognitive and psychological functioning, as well as the demonstrated ability to apply these changes to real life situations. The treatment plan is one of the vehicles that document these changes.

- **Unplanned unsuccessful discharge**: This happens when the ward leaves or is removed from treatment suddenly, so that no planning for discharge is possible, and before all or any treatment goals are met. In these situations (if the ward is still in the facility) regular follow-up with the individual will determine if and when they are ready to engage in treatment again.

- **Planned administrative discharge**: This kind of discharge from the treatment program is necessary when a ward's behavior becomes a serious threat to either themselves or others and regular behavioral management interventions have been unsuccessful, or when the ward has been unresponsive to treatment over a significant period of time. Again, in this situation regular follow-ups with the ward will determine if and when they are ready to re-engage in treatment.

RESDIENTIAL TREATMENT PROGRAM:

The plan calls for four residential programs, which would serve a total of about 200 wards. These are Humboldt at OH Close, Feather at NA Chadejerian; Carter at FC Nelles, and J Company at HG Stark. Humboldt and Carter have been in operation for some time, and Feather and J Company opened the summer of 2003. The following are the stated program goals:

- **Program components**
    - Sex offender group – 6 or 7 wards – 3 hours weekly
    - Large group – 2 groups per week – 4 hours weekly
    - Resources group – 2 groups per week – 3 hours weekly
    - Individual treatment work – 4 hours weekly
    - Sex Offender Treatment Homework – 6 hours
    - Sex offender specific program – 20 hours

- **Proposed Staffing** for 50 – 60 wards
    - One fulltime program administrator
    - One supervising casework specialist
    - One senior youth correctional counselor
    - One case work specialist
    - 8-9 youth correction counselors on 50 bed programs with closed dorms
    - 10 youth correctional counselors on a 60 bed program with open dorms
    - One office technician
    - 3 psychologists, one specializing in developmentally delayed wards, and one in psychopathic wards.
    - 9 youth correctional counselors, 3 assigned to each psychologist

Reviewer Comments: This is an excellent plan and well conceived. With the addition of some details it will meet standards of practice.

- **Resources Groups** (2 groups per week) that includes Core: 1) Victim's Awareness, 2) Criminal Thinking Errors, Addictive Behavior, 4) Human Sexuality, (5) Human Interaction/Social Skills as well as additional resource groups as prescribed by treatment team 6) Recovery, 7) Stress Management and 8) Anger management – 3 hours.

  Reviewer Comments: The suggestions for the resource groups are excellent. The curricula for the groups were designed with the CYA population in mind and so the exercises and homework are applicable to that particular population. It has also been developed so that it can be modified to meet individual needs – such as those of the developmentally delayed. These particular resource groups are important because they all cover areas that are known to be problem areas for

sexually abusive youth. The resource groups are designed to teach skills that will overcome those problems.

For example:

- Human Sexuality: One study of 1600 juveniles found that only about one third of the subjects perceived sex as a way to demonstrate love or caring for another person. The others perceived sex as a way to feel power and control to dissipate anger, or to hurt, degrade or punish (Ryan et al 1996). In addition, the majority of sexual abusers admitted the use of hard-core porn, which objectifies the sex partner (Ford and Linney, (1997); Becker and Stein (1994)).

- Social skills: Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence, (Becker (1990); Knight and Prentky, (1993)). Numerous other studies point out the fact that sexually abusive juveniles have inadequate social skills, poor peer relationships, and experience a great deal of social isolation (Kat, (1990); Miner and Crimmins (1995)). For these reasons it is routine for programs to address interpersonal skills in a variety of different ways, and to avoid the use of social isolation as punishment for behavior problems. This is another reason why the therapeutic milieu is so important, through providing wards opportunities to really use these skills, not just participate in academic learning.

- Criminal Thinking Errors or Cognitive Distortions: Literature as well as research suggests that cognitive distortions, such as blaming victims, are associated with sexual reoffending in juveniles (Kahn and Chambers (1991)).

- Victim Awareness: It is commonly believed, though not proven by research, that developing an awareness of the suffering of victims and being able to be empathic will be a deterrent to future offending.

- Recovery: The following are commonly found in the backgrounds of juveniles with sexually abusive behavior problems: being sexually abused; being physically abused; witnessing family violence; being neglected (Kahn and Chambers (1991); Kobashi, et al (1995); Ryan et al, (1996)). Many of the above factors also exist in the backgrounds of all delinquents, and the role of these experiences as they relate to the development of sexual offending is quite complex (Prentky, et al (2000)).

- Addictive Behavior: This is behavior which has compulsive and physiological component and is believed by some to be part of sexual offending or to support sexual offending behavior. It is the model for substance abuse treatment.

- Stress Management: Cortoni and Marshall (2001) studied sexual activity functions as a coping strategy for sexual offenders among 89 incarcerated offenders. Sexual offenders reported using sexual activities, both consenting and non-consenting as a coping strategy for stressful and problematic situations at a higher rate than non-sexual offenders. When compared to non-sex offenders, sex offenders evidenced a sexual preoccupation during adolescence, which was related to the use of sex as a coping strategy.

- Anger Management: There is research that indicates that sexual behavior may be the externalization of emotions that cannot be resolved and that anger and hurt may be at the root of those emotions. Therefore, teaching how to manage anger is an important part of the treatment program.

Recommendations: The following are suggestions that will enhance the program but are not critical to meeting basic standards of care.

- Consider a few other resource groups as well, such as problem solving, conflict resolution, parenting, job skills, and dating/ healthy sexuality skills for example or make sure that these subjects are part of the learning experience somewhere in the program.

- Professionals who specialize in working with special populations such as the developmentally delayed, those with attention deficit disorder, psychopaths and female sex offenders have developed materials to use with these populations. Although we have been modifying materials for populations for years it makes sense to use the materials previously developed by the professionals who know them best.

- The Human Sexuality Curriculum is good, but it needs to be expanded and lengthened to include much more on the development of sexual values. The issue of unhealthy sexuality is at the core of these youth's problems. They know a lot about sex but nothing about healthy sexuality. They know a lot about the use of sex to get all sorts of needs met, but nothing about sex as part of a loving relationship. They have no dating skills, and are totally ignorant about the establishment of positive male-female relationships.

  Interviews with both wards and staff indicate that sexual attitudes are a problem not only in the sex offender population, but in the general population as well. Quote from wards: "there's a lot of sexual behavior going on that staff don't see". Quotes from staff, "Boundary issues are sometimes a problem, and there have been allegations of staff being inappropriate," and, "There is a real problem with the sexual harassment of staff."

In some cases sexual harassment refers to the fact that a ward masturbates so a female staff will see him, looks or leers at female staff in ways that are clearly sexual in nature, use sexual language, and watch female staff so intently that some perceive it

as a variation of stalking. None of these behaviors are unusual for sex offenders, and are to be expected. It is even important that the behaviors are seen so that staff will have an opportunity to confront and teach the wards involved. These behaviors are common and basic treatment issues for this population, and they need to be dealt with in ways, which are therapeutic rather than punitive. Punishment as such does not work, and some wards even find it enjoyable in direct proportion to punishment's severity and discomfort. Getting staff to punish them is one of the ways some wards manipulate unqualified and/ or inadequately trained staff.

Sexual Offender Residential Treatment Program Rules and Participation

- **Agreement**: The plan is for the ward to sign a statement that states the following: "I have participated in identifying the treatment objectives indicted on my individual needs assessment for the purpose of assisting me though the rehabilitative process." A similar statement identifies the staff's commitment to the wards and to the rehabilitative process.

Reviewer Comments: This treatment contract has been well written and serves the purpose of underlining the seriousness of the treatment contract both for the ward and for the staff. Everyone has responsibilities here that are important.

Recommendation: This is a good plan and there are no recommendations.

- **Definitions under Residential Program Curriculum:**

Fantasy log/tracking in the definitions section was left blank and needs more explanation.

Under Incest, sibling incest was excluded and needs to be noted.

Sexual abuser and sexual assault, the definition here is inadequate.

Sexual deviancy: this needs further definition.

Sex offender: This needs further definition.

Reviewers Comments: It is an excellent idea to define terminology for those who will read this document and are not familiar with this field.

Recommendation: The Center for Sex Offender Management has a glossary of sex offender terminology that could be helpful in definitions as does The National Task Force Report (1993)

- **Phases and Stages:** "The residential program is divided into 12 stages. 1-10 is provided in the residential program, stage 11 is provided on Maintenance in the general population, and stage 12 is provided on parole. The 10 residential stages are grouped into three phases, Orientation Core Program, and Relapse Prevention."(Program Overview, May 2003)

Reviewers Comments: Good plan that with a few additions will meet national standards of practice. Those additions will be noted under recommendations.

- **Orientation/Assessment Phase**

Assessment: The plan calls for assessments to be completed by stage three of Phase One, and refers to these as pre-treatment tests and assessments which are to be done again at the end of stage nine for post placement data.

Reviewer Comments: Keeping in mind that there is more than one assessment process necessary at more than one treatment stage this would be thought of as the needs based/treatment planning and the discharge evaluation assessment. Considering that the pre sentencing assessment had taken place as normal in most cases, then the assessment stages that should take place in the CYA by the end of stage three would be the needs based/treatment planning and at the end of stage nine - the treatment evaluation/pre discharge. The monitoring/follow-up assessments would be the responsibility of aftercare.

- **Core Program Phase**

Recommendation: The plans for this phase are good and there are no recommendations.

- **Relapse Prevention/stabilization phase:**

Reviewers Comments: This is one of the most important components of any sex offender treatment program. Relapse prevention helps an offender recognize situations that create a potential for relapse and identify ways of controlling deviant behavior or avoiding high risk situations.

Recommendation: Develop a policy and procedure for sharing this plan with all members of the support group.

- **Transition**

Recommendation: This is a good plan and there are no recommendations.

- **Therapeutic Relationship**: This identifies the importance of the therapist forming a therapeutic relationship with the ward in order for changes to take place.

Reviewers Comments: The importance of this has been covered in Question One along with recommendations made.

Additional program components needed as part of this plan:

- **The Assessment and Control of Deviant Sexual Arousal**: There is no planned policy or procedure to address this problem. In the past it has been left up to individual psychologists.

Reviewers Comments: Two different studies illustrate the need to pay special attention to the issue of deviant sexual arousal: The first: "Deviant sexual arousal is strongly associated with sexually coercive behavior (Barbaree and Marshall (1994); Earls and Quinsy (1994); Prentky and Knight (1993)). Sexual recidivism is associated with deviant sexual arousal (Schram, Milloy and Rowe (1991)).

The Center for Sex Offender Management in Washington published a paper in 1999 entitled "Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches and Management" This is what it says about deviant sexual arousal and young people: "A minority of sexually abusive youth manifest established deviant sexual arousal and interest patterns. 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 sexual arousal is more clearly established as a motivator of adult sexual offending, particularly as it relates to pedophilia. In general, the sexual arousal patterns of sexually abusive youth appear more changeable than those of adult sex offenders, and relate less directly to their patterns of offending behavior" (Hunter and Becker, 1994, Hunter et al, 1994)

Recommendation: It is important that CYA have a policy and procedure for the assessment and treatment of deviant sexual arousal. At this time it is being left up to the individual psychologists to address, which means there is no uniform method suggested or recommended for this important treatment intervention.

Assessment of sexual arousal can be made several different ways – through self-report or through the use of a device called the penile plethysmograph. The Abel Screen which screens for sexual interest is proposed by the CYA. Not all sex offenders have a problem with deviant sexual arousal but since it is an indicator o\f high risk it is important that it be assessed and treated when it does occur. There are a variety of accepted ways to address the reduction of deviant sexual arousal such as covert sensitization, assisted covert sensitization, olfactory conditioning and satiation therapy, and aversive behavioral

rehearsal. These are generally coupled with techniques for increasing appropriate sexual arousal.

The Abel Assessment for Interest in paraphilias which is suggested by the Sex Offender Work Group is a computer driven assessment approach that provides an evaluation of a juveniles sexual interest patterns based on his or her reaction times when viewing slides of potential sexually evocative stimuli. (Abel Screening, 1996 The Abel screen is relatively new but many programs are using this methodology.

Since deviant arousal is correlated with reoffending it is very important that a determination is made about whether or not it is a part of the offender's behavior patterns and for that reason the industry endorses the use of physiological measures as a way to determine whether or not this is present and to what extent. Self report is useful but not always fully truthful.

- **Family Counseling Component**: "In Stages three, six and nine, if willing and able the plan recommends a minimum of three family counseling sessions as well as the provision of a family handbook which includes information on how they can assist wards in their treatment and how to prepare for their treatment needs on parole. In stage three wards will disclose sexual offenses, disclose sexual assault cycle during stage six and review their relapse prevention plan during stage nine. The psychologist and YCC will facilitate the family counseling sessions" (Program Overview, May, 2003)

Reviewer Comments: While this is a good beginning it in no way meets standards of practice, which recommends family involvement in all programming for juvenile sex offenders. The national survey on sex offender programs showed that the average sex offender program had .81 family sessions per week. Three sessions in eighteen months will not suffice for residents who will be residing at home again, or who need major work with family to deal with family issues. However, the plan is a big improvement on the current one which has no planned family involvement.

Recommendation: The CYA needs to identify someone who is responsible for family assessment, treatment planning, reunification, and visitation and progress reports. My expectation is that this will require one more psychologist per residential program and one more per outpatient program.

- **Program Failures**: When wards are failing the program, the treatment team will hold a case conference to decide the proper course of action.

Reviewers Comments: This is an excellent policy for sex offender programs and facilitates planning for program failures. It is not always necessary to transfer wards and this is a proactive move to make decision making more informed.

Recommendation: The definition of failure must be very clear and the process for evaluating whether or not a ward is a program failure identified in policy and procedure.

- **Maintenance Phase:** The maintenance phase is in the outpatient program and is actually stage 11. It begins after the formal program has been completed in the residential program. It is the same for the outpatient program.

Reviewer Comments: A community reintegration policy and procedure is the norm for most residential programs. The reason for this is that it is much easier for youth to behave in prosaically ways in a restricted environment and the goal is to see if they can practice those behaviors in a real community environment. These experiences can range from mainstreaming back into the public schools, outings with family members; to volunteer and paid job experience. Since this would be a huge logistic and resource problem for CYA, the plan to move the youth back into the general population for a maintenance phase is a good one. This will give the wards the opportunity to experience a new environment, one that will be new and probably uncomfortable, in order to see if non offending skills and behaviors have been internalized and will be transferred to another situation.

Recommendation: None

- **Parole:** Parole is planned as the aftercare part of the program.

Reviewers Comments: "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 the initial assessment and treatment. It is the part of treatment that most directly connects with the juvenile's future"
(National Adolescent Perpetrator Task Force Report, 1993)

Research indicates that the post-discharge environment is a powerful factor in determining the successful long-term adjustment of individuals who have completed residential programs. This is a necessary part of any sex offender program and without plans for it the program is incomplete.

Recommendations: The piece of this plan that is missing is the development of what is sometimes called a relapse prevention support group, a support group, and a circle of support or a containment team. These are the people in one's life that will monitor and provide support for the ward in the community. There are protocols for support groups that can serve as the model for CYA to develop the policy.

OUTPATIENT TREATMENT PROGRAM:

"Each institution (about 400 – 500 wards) will have an outpatient program and this includes the Intensive Treatment Programs, the Specialized Counseling Programs and the

Specialized Behavior Treatment Programs (about 75 wards) The offenders slotted to be treated in the residential programs for whom there is not a space will remain in the general population and begin treatment in outpatient groups until there is an opening in the appropriate residential treatment program." For this reason the outpatient and residential programs are very similar.

Reviewers Comments: Comments about the outpatient program model have been made in other sections of this document so need not be made again.

Recommendation: Instead of placing the wards with special problems in the Intensive Treatment Program, the Specialized Counseling Programs and the Specialized Behavior Treatment Programs, it would be much more effective and appropriate to develop Dual Diagnosis programs for sexually abusive wards.

- **Treatment Program for the Outpatient Group**: The plan is for 10 hours of sex offender specific treatment a week. This consists of: one sex offender group – 2hrs. Per week, 1 core resource group – 1.5 hrs per week; individual work of .5 hrs per week and homework -6 hours.

  Again there are four phases and ten stages with 11 being maintenance and 12 transitions, which is parole. The phases are the same – the orientation phase, the core program phase, the relapse prevention phase and the transition phase. The program has been made similar to the residential program to make movement between the two easier.

Reviewer Comments: If there is a population within the California Youth Authority that is appropriate for an outpatient program, and if this could be worked out logistically, then this might be workable plan. This model would have a good chance of working in the intensive treatment program, the specialized treatment program and the behavior management treatment program if these programs would develop a therapeutic milieu. A therapeutic milieu is very appropriate for any mental health program. In the general population outpatient programs I have serious doubts if this could be manageable, especially for the large numbers indicated.

Recommendation: Prior to putting any outpatient plan in place, conduct a needs assessment of the sex offenders currently in the general population to see if this kind of treatment could be workable. For example, one of the criteria mentioned is that the outpatient population would be motivated for treatment. How many of the current population is motivated for treatment? In addition work with the current staff of institutions to see what tithe problems will be logistically to managing this program and how these problems would have to be worked out. Two concerns which will make this difficult to accomplish: there is not enough staff allocated to these programs and the absence of a therapeutic milieu will cause numerous behavioral as well as treatment problems.

- **Staffing for the Outpatient program**: The plan is for there to be one psychologist per institution who along with one designated staff from the program to coordinate the program for the general population, co lead the groups, and coordinate movement to the groups and provide security during the groups. There will be a parole agent assigned to write progress reports and to lead resource groups.

  The five core groups are victim awareness, criminal thinking errors, addictive behavior, human sexuality and human interaction social skills."

Recommendation: Develop a time and task system to see if what is required of these staff members is even possible. Without doing an extensive assessment it is difficult to see if this will be enough staff.

- **Maintenance Stage:** Maintenance stage for outpatient occurs in the general population as it does for the residential program. The goal is to continue to reinforce the concepts, therapeutic issues and relapse prevention techniques covered during the first 10 states. The maintenance group will come from both the outpatient and residential programs.

Reviewers Comments: The concept of a maintenance stage is a good idea in view of the fact that normal community reintegration activates cannot take place.

Recommendation: The maintenance stage needs to include some experiences that one would expect in the world outside the institution. These can be facilitated with role-plays, drama therapy and the facilitation of some normalization of experiences.

- **Parole Stage 12**: Parole preparation is part of the maintenance stage. The planned parole program is the component of the program considered after care. This program may include weekly group counseling and the individual counseling curriculum will be similar to those in curricula groups.

Reviewers Comments: Good plan and usually the standard for most programs.

Recommendation: Work with parole as closely as possible at facilitating this and planning staff collaboration at all stages.

Wards with Special Needs:

1. **Developmentally Disabled/Low Cognitive Functioning sex offenders**

At least one group will be designated for developmentally delayed at each institution in the outpatient programs. Each residential program will have one psychologist and approximately 3 youth correctional counselors specially trained to treat lower functioning wards. Additional hours of annual training are planned for this staff.

The coordinator monitors the numbers to make sure they are even in the programs and will oversee additional training.

Recommendations: Plan for additional training of the outpatient staff as well as the residential staff. There are many good resource materials being developed particularly for this population and so instead of modifying for the developmentally delayed I would start with new materials designed with them in mind.

2. **Psychopathic Sex Offenders:**

The plan is for the psychologist to administer the Hare Psychopath Check list to any wards on their caseloads that they consider psychopathic. Psychopathic wards will be placed on one caseload and psychologist that covers this caseload will receive an additional 16 hours of training:

Reviewer Comments: This plan is what experts in working usually recommend for this population with psychopaths.

Recommendations: None

3. **Cases on Appeal:** The program coordinator will track and monitor the appeal if related to sexually offending so that can be placed in-group at appropriate time

Reviewer Comments: This is a good plan and will prevent wards from falling between the cracks as they do at this time.

Recommendations: None

4. **Wards in Special Management Programs/Recalcitrant Wards:** Providing on an individual basis – doesn't have how often they will meet with them.

Reviewers Comments: The special management programs as designed for the CYA are designed for punishment not correction. Without a teaching correction model wards just learn to outlast the punishment so that they can do what they did again.

Recommendations: The sex offender programs need their own design for special management procedures for wards. The response of sexual offenders is often counterproductive to the typical measures used. For example: Sex offenders generally like to be isolated so isolation is not a good management program for them. The more isolation the more time for deviant fantasies and get back schemes for them.

Any plan needs to include the number of contacts required, the amount of time required, who is responsible and who monitors for quality control.

- **Case Conference:** This is planned for every sixty days with all members of the treatment team.

Recommendation: Good plan, no recommendations.

- **Large Group**: This is planned to handle living issues in the community. For sex offenders this is often a case of the program being actualized in the living environment.

Recommendation: Good plan, no recommendations.

- **Staff Training:** The comment at the beginning of this section mentions that the high degree of turnover as result of post and bid (staffing in relationship to seniority bidding makes more training critical.

Reviewers Comments: Basically, this is an excellent plan and is comparable with dozens of other training plans that have been reviewed. The numbers of hours in sex offender training are comparable with what is considered good practice. This plan needs to be expanded to include a policy and procedure for developing and implementing training curricula.

Staff needs a mandate for certain hours of training prior to being in direct contact with sexually abusive youth – the psychologists need more intensive training than the rest of the staff. The rest of the staff needs to have a great deal of practical training in how to with these particular wards. Also training should be competency based and a plan developed to indicate how competencies will be measured.

This plan also needs to indicate how training competencies will be measured.

Recommendation: Recommendations are made in Question One.

- **Polygraph**: The plan calls for the use of the polygraph. The purpose of a

polygraph examination is to verify a perpetrators completeness regarding offense history and compliance with therapeutic directives and terms of supervision (Emerick and Dutton, (1993)). There is more research data on the use of the polygraphy with adult sexual offenders than there is with juveniles and it is not recommended for use for youth under 14.

In Texas, law requires use of the polygraph on certain sexually abusive youth. In 1997 legislation was enacted that prescribed release conditions including counseling and treatment for adolescents convicted of certain sex offenses. Under this law, youth can be required as a condition of release from the "Texas Youth 'Commission to attend psychological counseling sessions and to submit to polygraph examinations in order to evaluate treatment progress (Texas Human Resources Code, Title 3, Ch 21, Sub.A, Sec. 61.0813).

Reviewers Comments: The following data makes a strong case for the use of the polygraph:

- Research on use of polygraph with juveniles: (Emerick and Dutton, (1993, 1997))
  Victims at intake - 1.87, after polygraph - 2.85
  Offenses at intake - 20.65, after polygraph - 76.59
  Pornography use at intake - 27%, after polygraph – 78%
  Voyeurism at intake – 29, and after polygraph - 49
  Rape at intake - 15, and after polygraph - 29
  Fetish at intake – 12, and after polygraph - 24

Recommendation: The CYA should utilize the use of the polygraph, along with the standards for its use developed by the Center for Sex Offender Management.

- **Megans Law:** The plan gives a very comprehensive overview of Megans' Law and the registration of sex offenders.

Recommendation: Very well done, no recommendations.

- **Research Component:** Recommended for every sex offense specific programming – with out this component there is no way to track if programs are being effective, if wards are recidivating, if the programs are delivering the treatment components:

Recommendation: Excellent plan and no recommendations.

- **Performance Standards**: These performance standards meet best practice guidelines. They must be adopted as policy along with a design for using them to evaluate programs.

There are several issues not covered as part of the plan that should be as part of any comprehensive plan. They include the following:

- **Suitable Staff**: This issue was covered in question one and is an important part of any program proposal. As a paper written for the National Institute of Corrections (1988) states, "The most effective therapists, either professional or paraprofessional, have personalities suitable to working with this group"

- **Program Integration:** This issue was also covered in question one along with the reasons for the importance of program integration.

Summary: This program evaluation has been as comprehensive as the allotment of time and resources made possible. The California Youth Authority has been very gracious in allowing me the opportunity to conduct this evaluation. Although the final conclusion may look very negative, these are not my feelings about the Youth Authority, its staff or its potential for improvement.

Respectfully submitted,

Jerry Thomas
Jthomas Consulting and Training Services

Addendum A

PERSONAL AND GROUP INTERVIEWS CONDUCTED AS PART OF THE EVALUATION OF THE CALIFORNIA YOUTH AUTHORITY SEX OFFENDER PROGRAMS:

The following does not include every name of every person spoken to as some of the conversations were quite informal, not scheduled, or only in passing.

Orientation Meeting:

- **Expert Witnesses**
- **California Youth Authority Representatives**
- **Prison Law Office Representatives**

California Youth Authority Central Office, Sacramento:

- Jerry Harper, Director, Department of the Youth Authority
- Kip Lowe, Assistant Deputy Director
- Jack Wallace, Youth Authority Administrator, Mental Health
- Deborah Johnson, Sex Offender Task Force Coordinator, Sex Offender Program Manager
- William Berndt, Office of Population Management, Parole Agent III
- Steve Stenoski, Youth Authority Administrator, Program Compliance Unit
- Jill Weston, Office of Victim Service, Parole Agent II
- Teresa Isorena, Office of Research, Research Analyst
- Carrie Ross Price, Office of Ombudsman
- Sherrie Ellis, Office of the Ombudsman
- J. P. Trembley, Compliance Unit
- Dr. William Schouweiler, Psychologist

Humboldt Sex Offender Program:
OH Close Youth Correctional Facility, Stockton

- Tim Mahoney, Assistant Superintendent
- Yvette Marc-Aurele, Deputy Superintendent
- Ana Diaz, Supervising Case Work Specialist

- Howard Penn, Senior Youth Correctional Counselor
- Jim Lawrence, Parole Agent 1
- Tom Casillas, Youth Correctional Counselor
- Dr. Marsha Asgarian, Staff Psychologist
- Dr. Heather Bowlds, Staff Psychologist
- Rosa Rivera, Program Administrator
- Dr. Kim Sutterfield, Staff Psychologist
- Dr. Sanford Ditzen, Senior Psychologist
- Laurie Randall, Parole Agent III
- Dr. Linda Gillespie, Principal
- Donna Reed, Teacher
- Dave Ford, Parole Agent I
- Kyle Starr, Lieutenant

- Five Wards interviewed – picked at random

Preston Youth Correctional Agency, Ione

- Jeff Harada, Superintendent
- Elaine Stenoski, Program Manager
- Heyman Matlock, Assistant Superintendent
- Dr. Peter Schumsky, Staff Psychologist
- Joe Shofner, Treatment Team Supervisor
- Dr. Eldon Olson, Sr. Psychologist

Five Wards Interviewed, picked at random

Northern California Youth Correctional Reception Center and Clinic, Sacramento

- Dr. Selmer Wathney, Senior Psychologist
- Sharon Shumsky, Supervising Casework Specialist
- Dana Brown, Casework Specialist

Feather Program
N.A. Chaderjian Youth Correctional Facility, Stockton

- Steve Kruse, Assistant Superintendent
- Jack Karver, Program Administrator
- Dr. Sophia Johnson, Staff Psychologist

Five Wards picked from a list of wards

Carter Sex Offender Program
Fred C. Nelles Youth Correctional Facility, Whittier

- Vivian Crawford, Superintendent
- Ted Bonzon, Supervising Casework Specialist
- Elverta Mock, Program Administrator
- Judy Han, Casework Specialist
- Dr. Deborah Leong, Staff Psychologist
- Dr. Regina Uliana, Staff Psychologist
- Mike Owens, Parole Agent II
- Ernie Owens, Youth Correctional Counselor
- Jesse Miranda, Youth Correctional Counselor

Interviewed group of eight wards

Ventura Youth Correctional Center, Ventura

- Al Polomino, Parole Agent III
- Dr. Anne Marie Donnelly, Staff Psychologist
- Ricardo Hernandez, Youth Correctional Counselor

Group of six females wards
Group of six male wards

Sacramento Parole:

- Kevin Davila, parole agent II

Addendum B

LIST OF DOCUMENTS REVIEWED FOR CALIFORNIA YOUTH AUTHORITY SEXUAL OFFENDER PROGRAM EVALUATION

Documents Reviewed at all CYA Sex Offender Programs:

- *A random review of 5 – 7 charts*
- *A random review of behavior reports and incident reports*
- *A random review of ward written work assignments*

Documents Reviewed from the California Youth Authority Central Office:

- *Chris Stevens, et al vs. Jerry L. Harper, Director CYA, and the California Youth Authority: Memorandum of Opinion and Order, September 11th, 2002.*
- *Chris Stevens, et al vs. Jerry L. Harper, Director CYA, and the California Youth Authority: Second Amended Complaint, February 15th, 2002.*
- *Margaret Farrell vs. Jerry L. Harper, Director CYA, and the California Youth Authority: Complaint for Injunctive and Declaratory Relief, January 16th, 2003.*
- *Chris Stevens, et al vs. Jerry Harper, et al: Stipulated Protective Order Regarding Confidentiality of Ward, Inmate, Patient, and Student Records, California Youth Authority, Personnel and Office of Inspector General Information, October 24th, 2002.*
- *"Chris Steven, et al vs. Jerry L. Harper, et al," Second Amended Complaint.*
- *Notebook of information from the Prison Law Office*
- *Notebook of Information from the California Youth Authority*
- *Task Force Report: "The California Youth Authority Sex Offender Treatment Program", 04/11/03*

- *"Ward Handbook, Stages 4-6," Residential Sex Offender Treatment Program, CYA, March, 2003.*

- *"Residential and Outpatient Treatment for all Sex Offenders," Overview Manual, January, 2003, California Youth Authority Sex Offender Treatment Program.*

- *"Residential Treatment Program and Curriculum," Program Manual, May, 2003, California Youth Authority Sex Offender Treatment Program.*

- *"Outpatient Treatment Program and Curriculum," Program Manual, May, 2003, California Youth Authority Sex Offender Treatment Program.*

- *Sex Offender Referral Document*

- *California Department of the Youth Authority Annual Report - 2001*

- *Major Assembly Actions May 30, 2002*

- *California Youth Authority Sex Offender Placement Priority List (Sorted by Location), 11/25/2002.*

- *Population Management Center System SORD Roster, 04/01/03*

- *"Population Management and Facilities Master Plan, 2001-2006, 5 Year Population Management and Facilities Master Plan, 2002-2007"*

- *"The California Experience," by Jerry Harper, Director, California Department of the Youth Authority*

- *Sex Offender Referral Document (SORD), Developed by the State of California Department of the Youth Authority.*

- *Sex Offender Placement Priority List.*

- *"Doing Justice? Criminal Offenders with Developmental Disabilities," by Joan Petersilia, California Policy Research Center Brief Series, August, 2000*

- *Summary of Facts of the 1996 Murder of CYA Guard Inese Baker and the Ensuing Federal Civil Rights Suit in Her Name*

- *"California Policy, Violent Offenders, Resources," by Franklin E. Zimring and Gordon Hawkins*

- *Sex Offender Continuity of Treatment Task Force Meeting Minutes, 1/8/03 – 1/10/03*

- *"Mental Health in the CYA," Steiner, Humphreys & Redlich, Stanford University, 2001*

- *"Report of Forensic Mental Health Assessment: Mental Health Services to California Youth Authority," by Dennis F. Koson and Joel A. Dvoskin, July 5th, 2001, A statewide evaluation of CYA mental health services at the request of the CYA's Dr. Kevin Lowe*

- *Memo to Senator John L. Burton, Chairman California Senate Rules Committee from Steve White, California Inspector General re: Senator Burton's "request for information about the availability of ward programs ordered by the Youthful Offender Parole Board." April 5th, 2002.*

- *"Mental Health Augmentation, Department of the Youth Authority Budget Concept Paper, Fiscal Year 2003-2004," by Jack Wallace*

- *"Budget Services Bureau Budget Change Proposal Analysis, Fiscal Year 2002-2003," BCP Number/Title: I&C #01- Mental Health Resources, prepared by Scott Maple, June 24th, 2001.*

- *"Mental Health Services, Department of the Youth Authority Budget Concept Paper, Fiscal Year 2002-2003," prepared by K. Lowe.*

- *"California Youth Authority Sex Offender Treatment Programs Document Index.*

- *"State of California Capital Outlay Budget Change Proposal, Budget Year 2002-2003: Project Title: O.H. Close Youth Correctional Facility- 50 Bed Sex Offender Program (SOP)," Project ID: 60.26.195*

- *"Sex Offender Treatment Skills for Corrections Professionals," National Institute of Corrections, U.S. Department of Justice.*

- *Sex Offender Developmental Model (SORTS, 1994), 1 page overview diagram*
- *Memo to Psychologists, TTS', Pas, and SYCCs from Dr. Wettimuny, Chief Medical Officer and Debra Cacianti, Senior Psych re: "Medical and Mental Health Services"*

- *"An Administrator's Overview: Questions and Answers on Issues Related to the Incarcerated Male Sex Offender," National Institute of Corrections, U.S. Department of Justice, October, 1988*

- *"Mental Health in the California Youth Authority," by Steiner, Humphreys and Redlich, Stanford University, 2001.*

- *California Youth Authority Treatment Needs Assessment*

- *"Sex Offender Resource Development Work Group Field Report, 9/20/95"*
- *"New Member Packet, Juvenile Sexuality Program, Sexual History Preparation," The Hindman Foundation.*
- *"Selected Characteristics of Institution Population as of December 31 Each Year 1992 through 2001," Department of the Youth Authority.*
- *"Ward Grievance Digest: Arbitration Hearings November, 1997 to July, 2001," California Department of the Youth Authority.*
- *"Evaluation of the Ward Grievance Procedure," LPC Consulting Associates, revised May 24th, 2002, An evaluation solicited by the California Youth Authority.*
- *"Ward Grievance Policy and Disciplinary Decision Making System (DDMS), Policies and Procedures," California Youth Authority, May, 2001*
- *"Transfer of Knowledge Workshop for Prevention of Sexual Reoffending Manual," California Youth Authority Training Center, February 22nd-25th, 2000*
- *"Victim Impact: Classes/ Panels," Psycho educational Materials, California Youth Authority.*
- *"New Member Packet, Juvenile Sexuality Program, Sexual History Preparation, Part I," It's About Childhood, the Hindman Foundation.*
- *"Charting a New Course: Corrective Thinking Curriculum," by David W. Koermer and Rogie A. Spon, 1999, Truthought Publications, Truthought, LLC.*
- *California Youth Authority Sex Offender Placement Priority List, 1/24/2003*
- *Office of the Inspector General, Review of the Youthful Offender Parole Board, Attachment B* (6 page attachment including, "Board Ordered Programs and CYA Offerings"; "Summary of CYA Programs- Duration, Frequency, & Hours"; "Summary of Programs"; "Maximum Program Capacity"; "Number of Wards Currently Enrolled in the Program"; and, "Number of Wards on Waiting Lists".
- *"Population Management and Facilities Master Plan, 2001-2006," California Youth Authority.*
- *"California Youth Authority Psychologist Work Activities Survey, July, 2002," California Youth Authority.*

Humboldt Sex Offender Program Documents

- *"Humboldt Hall Formal Sex Offender Treatment, Program Guide and Orientation Booklet," O.H. Close Youth Correctional Facility, California Youth Authority.*

- *"O.H. Close Youth Correctional Facility, Humboldt Specialized Counseling Program for Adolescent Sex Offenders"*

- *"Explanation of the Humboldt Formalized Sex Offender treatment Program", C. Fugate, O4/07/0*

- *O.H. Close Correctional Facility Organizational Chart*

- *"Humboldt Formalized Sex Offender Program Explanation of Treatment," December 1st, 2000.*

- *"Relapse Prevention Plan," by a CYA Ward, O.H. Close- Humboldt, April, 2002.*

- *"Duty Statement and Performance Standards," Program Administrator-Specialized Counseling Program, O.H. Close Correctional Facility.*

- *"Standards and Duties," Youth Correctional Counselor, O.H. Close Youth Correctional Facility.*

- *"Standard and Duties," Senior Correctional Counselor, O.H. Close Youth Correctional Facility.*

- *O.H. Close Youth Correctional Facility Staff Schedule, February, 2003*

- *Collected Psycho educational Materials:*

- *"Anger Management," Skill Building Resources for Increasing Social Competency.*
- *"Anger Management," collected articles and worksheets, Humboldt program.*
- *"Criminal Thinking Errors," YCC Treatment Packet, Adapted from Yochelson & Samenow, The Criminal Personality,*
- *"Common Thinking Errors Used by Sexual Offenders," Humboldt treatment handout, adapted from Samenow & Stanton, "Errors in Thinking," 1988.*
- *"Lifeskills," handbook and worksheets for Lifeskills curriculum.*
- *"Self Esteem," miscellaneous collected materials and worksheets.*
- *"Career Awareness," curriculum handbook, materials and worksheets.*
- *Miscellaneous handouts on: Relapse prevention model, Sexual History Preparation, Defense Mechanism Definitions, The Anger Trap, Relaxation*

Exercises, Dysfunctional cycle information, Sexual assault cycles, Problem Solving, Sex Offending Behavior, Deviant Sexual Fantasy Journal, Levels of treatment, Identifying a cycle, Offender Wheel, Anger Management Principles

- *"When You Become 18: A survival guide for teenagers," Paul Bergman and Kenneth R. Pivo, 1996, California Law Advocates*
- *."Charting a New Course Corrective Thinking – Corrective Thinking Curriculum" by Rogie Spon and David Koerner*
- *"Male Female Relationships Curriculum" by Korsennik and Flynn*
- *"Young Men as Fathers: Topic and Direction Statements," Program Manual and Materials, California Youth Authority.*

- *Ward Grievance Policy and Disciplinary Decision Making System*

Carter Sex Offender Program Documents:

- *Outline of Carter Sex Offender Program*

- *"Sexual Offender Pre-Treatment Packet, Understanding Power and Control Issues"*

- *Staff Memo re: "Preventing Sex Offenders from Reoffending" Training Workshop, 2/22-25, 2000, by Elverta M. Mock*

- *Memo to Ted Bonzon from R.L. Uliana, 11/20/02, re: "Summary of Criminal Justice Conference 10/25/02"*

- *Carter Program Psycho educational Program Materials*
- *"Relapse Prevention," Carter Program Workbook.*
- *"Find Your Future: A Guide to College for Prospective Students," by Nick Wellenstein, Transition Coordinator, Fred C. Nelles Youth Correctional Facility.*
- *Job Corps information handout, Employment and Training Administration, U.S. Department of Labor.*
- *"Controlling Your Fantasies," Carter Program Workbook.*
- *"My Offense Cycle," Carter Program Workbook.*
- *"My Autobiography," Carter Program Workbook.*
- *"Narrative Workbook," Carter Program Workbook.*
- *"Relapse Prevention Workbook," by Safer Society.*
- *"Young Men as Fathers, Transfer of Knowledge (TOK) Workshop Materials," California Department of Health Services, March 6-8, 2001, Stockton, CA.*
- *"Anger Awareness," Ward Treatment Handbook.*
- *"The Offender Cycle," Ward Treatment Handbook.*
- *"Sex Offender Packet," Ward Treatment Handbook.*
- *"Controlling Your Fantasies," Ward Treatment Handbook*

- *"Anger Management," Skill Building Resources for Increasing Social Competency.*
- *Fred C. Nelles Youth Correctional Facility, Carter Cottage, Adolescent Sex Offender Program Staff Meeting Agendas*
- *"Carter Sex Offender Program: Team Meeting, December 14, 2001," notebook of minutes and collected materials and articles covered in the meeting.*
- *Staff Resumes*
- *"A Study of 'Relating to Women' Group and Young Adult Male Rape Offenders," by Elverta Marie Mock, Spring, 1985.*
- *Carter Cottage List of Youth Correctional Counselors and Their Assigned Wards, March 14th, 2003*
- *Carter Cottage Daily Casework Schedule, 03/03/03 and O3/21/03*
- *Fred C. Nelles (ID 0750A) "Case Report Transmittal Slip"*
- *Carter Cottage Grievance Records List, 11/30/01 to 03/05/03*
- *Self-Chosen Random Sample of Grievance Reports and Associated Documentation selected using "Carter Cottage Grievance Records List, 11/30/01 to 03/05/03"*
- *"Fred C. Nelles Youth Correctional Facility Carter Adolescent Sex Offender Program, Phase System and Living Unit Rules Ward Manual," Draft, revised February, 2003.*
- *Department of the Youth Authority: Wards in Institutions Committed for Sex Offenses (Fred C. Nelles Only), 03/05/03*

N. C. Chaderjian Documents: (Proposed Feather Program)

- *Review of Behavior Reports and Incident Reports.*

Northern Clinic and Reception Center

- *Policy and Procedure Manual*
- *Copies of psychological surveys used at the clinic*

GENERAL RESOURCES REVIEWED:

- *"A Comprehensive Bibliography of Scholarly Research and Literature Relating to Juvenile Sex Offenders," Updated 1992 by Cindy Smith, Kimberly Craig, Pamela Loose, Sallie Brodus, and Cynthea Kimmelman, Original Compilation by K. Craig, C. Smith, Barbara Hayler, & Lynn Pardie, Office of Juvenile Justice and Delinquency Prevention.*

- *"Recidivism of Sex Offenders," Tim Bynum, Michigan State University, for the Center for Sex Offender Management, by grant from the Office of Justice Programs, U.S. Department of Justice, May, 2001*

- *Sex Offender Task Force Report, State Of California, January 1986*

- *"Minnesota Rules, Chapter 2955: Residential Treatment of Juvenile Sex Offenders: Guidelines for the Basic Treatment Protocol, Therapeutic Milieu, and Quality Assurance/ Program Improvement Plan," by Alan Listiak, Minnesota Department of Corrections.*

- *"Sexual Offender Treatment Program: Initial Recidivism Study- Executive Summary," University of Alaska Anchorage, Justice Center, Alaska Justice Statistical Analysis Center, Alaska Department of Corrections Offender Programs.*

- *Guidelines for the Basic Treatment Protocol, Therapeutic Milieu, and Quality Assurance/ Program Improvement Plan," by Alan Listiak, Minnesota Department of Corrections.*

- *Center for Sex Offender Management, Washington, DC.*
    - *Understanding Juvenile Sexual Offending Behavior, Emerging Research, Treatment Approaches and Management Practices. 1999*
    - *An Overview of Sex Offender Management, July 2002*
    - *Managing Sex Offenders in the Community: A Handbook to Guide Policymakers and Practitioners through a Planning and Implementation Process, April, 2002*
    - *Recidivism of Sex Offenders, May 2001*

- *Standards of Practice from the Following States: Utah, Illinois, Minnesota, Texas, Virginia, Colorado, and Arkansas*

- *The National Task Force Report on Juvenile Sexual Offending, published by The National Council of Juvenile and Family Court Judges, Reno, Nevada, 1993.*

- *ATSA Standards of Practice, published by the Association for the Treatment of Sexual Abusers, 2001.*

- *The National Standards for Sex Offense Specific Programs for Sexually Abusive Youth, published by NEARI Press, 1999.*

- *A Protocol for Responding to Juvenile Sex Offenders, Missouri Juvenile Sexual Perpetrator Network*

- *"The Management of Sex Offenders," Council on Sex Offender Treatment, Texas Department of Health.*

- *"Requirements and Procedures for Credentialing as a Specialist in the Assessment and Treatment of Sexually Abusive Youth," Massachusetts Adolescent Sexual Offender Coalition, 1998.*

- *A Plan for the Treatment of Youthful Sexual Offenders in Tennessee, 1986*

- *"Virginia Department of Juvenile Justice Sex Offender Services Procedure Manual Appendix B," by J. Wallace.*

- *Colorado Standards of Practice for Juvenile Sex Offenders , Colorado Sex Offender Management Board, 2002*

- *"Colorado Rules: Presentence Investigations of Juveniles Who Have Committed Sexual Offenses."*

- *"The Collaborative Approach to Sex Offender Management," Center for Sex Offender Management, Washington, DC, October, 2001.*

- *"Identifying Sources for Managing Sex Offenders," Center for Sex Offender Management, October, 1999.*

- *"An Evaluation of Specialized Treatment for Adolescent Sexual Offenders: An outline for a national multi-site investigation," by Guy Bourgon (Project Manager, Network for Research on Crime & Justice), James Worling (Ontario Ministry of Community & Social Services), Stephen Wormith (Ontario Ministry of the Solicitor General and Correctional Services), and Irving Kulik (Executive Director, Network for Research on Crime and Justice), Fall, 1999.*

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Addendum C

Observation
California Youth Authority Sex Offender Programs

- Physical tour of all programs
- Preliminary Assessment of physical plants for safety
- Observation of program milieu at different times
- Observation of staff/ward interactions
- Observation of staff/staff interactions
- Observation of ward/ward interaction
- Observation of therapy groups at Humboldt, Carter, Preston, and Ventura
- Observation of community groups at Humboldt, Carter, and Preston
- Observation of Case Management Meeting
- Observation of three treatment team meetings
- Observation of culinary program at Preston
- Observation of wards involved in grounds maintenance
- Observation of transitions
- Case Management Meetings
- Parole Hearing
- Treatment Team Meetings

Addendum D:

Sexual Abuse as a Public Health Issue

Recognizing that the impact of sexual abuse on society is so devastating, several respected organizations have identified it as a serious public health concern. These organizations include The Center for Disease Control, The American Medical Association and The World Health Assembly. The American Medical Association (AMA) labels sexual assault as a "silent violent epidemic in the United States today." The statistics of the mental health, social services and correctional populations alone reveal that considerable percentages of those populations were the victims of sexual assault as children. The time and resources of numerous government and private agencies are spent in the prevention of sexual abuse, as well as in addressing the aftermath. There is no doubt that the failure to prevent sexual abuse will ultimately affect all of us in some way, personally, emotionally or financially

The serious harm caused by sex offenders underscores the significant need to develop methods of reducing the risks these offenders pose to society. Appropriate treatment of sexually abusive populations is only one of the ways to stop sexual abuse, but it is a vitally important one. Although the eradication of sexual abuse is unlikely, intervening appropriately and aggressively at every level can significantly decrease it.

Treatment Efficacy and Sex Offender Recidivism:

Some people may believe that certain acts or types of delinquent juveniles mitigate the State's responsibilities to these wards. In the case of juvenile sexual offenders this is generally because of the survival of several myths about sexually abusive youth. In particular, the beliefs that these juveniles are untreatable and have an uncontrollable compulsion to reoffend.

There has been an increase of general recidivism in the CYA. Many believe that this is due to the changes made by the CYA within the last decade from a rehabilitation model to a correctional model. At present, the total recidivism of all CYA parolee's ranges from 62-91%, depending largely upon the length of time after parole used in the measurement and the goals of the source. In only a single study by State correctional authorities, the "National Comparisons from State Recidivism Studies", by the Florida Department of Juvenile Justice (1999) did California not lead the nation in recidivism (Maryland 77%, CA 76%, NY 69%, and FL 63%).

Yet despite the conditions, which created this rise in juvenile recidivism in California, the recidivism of juvenile sex offender parolees in the Carter Program has remained much

lower compared to almost all other categories of parolee. A study of recidivism of the Carter Sexual Offender Program at the Fred C. Nelles facility indicated that only 23.5% of the study subjects committed a revocable offense of any type within 12 months, much lower than the recidivism rates of other populations. The August 2000 Implementation and Process Report by the California Continuum of Care Sex Offender Program (CCSOP) produced similar results. Numerous studies in the U.S. and Canada verify these trends in juvenile sex offender recidivism who have completed treatment. Recidivism being defined as rearrest. Some studies even report figures as low as 3-7% recidivism of all appropriately treated juvenile sexual offenders commit another sexual offense within 6 years (Becker, J.V. (1990); Borduin, C.M., Henggeler, S.W., Blaske, D.M., & Stein, R.J. (1990); Hall, G. C. (1995); Alexander, M.A. (1999); etc.).

The myths about the untreatability of these youth owe their origins to early efforts to apply generic, traditional mental health counseling methods to this population. These methods, which attempt to fit the client to the treatment rather than the treatment to the client, simply do not work, and would be a waste of taxpayer money if applied within the California Youth Authority (L. Furby, M.R. Weinrott and L. Blackshaw (1989); Borduin, C.M., Henggeler, S.W., Blaske, D.M., & Stein, R.J. (1990); etc.)

When the appropriate, specialized methods are used with this population, however, treatment can have a tremendous impact on the prevention of future offending behavior. In its 1998 "Review of Agency Program Effectiveness", a five year evaluation, the Texas Youth Commission reported that rearrest rates for any offense were reduced by 86% percent for those completing at least 12 months of specialized treatment. In 1991 Barry Maletzky, MD and Kevin McGovern, Ph.D. of the Sexual Abuse Clinic of Portland,

Oregon conducted a follow up study of roughly 5000 adult male offenders treated between 1973 and 1990 using specialized, behavior-oriented methods. Their criteria for "treatment success" included: no re-arrest; self-report of no maladaptive sexual behaviors; plethysmograph-verified reduced deviant arousal maintained post-treatment; and, specialists' evaluations of client responses and behavior. Applying these stringent measures to the subject offenders, some of who had concluded treatment as long as 17 years previously, success was achieved with 94.7% of pedophiles who targeted opposite-sex juveniles, and 86.4% of those who targeted same-sex children. Rapists showed 73.5% success, exhibitionists and public masturbators about 92%, and subjects referred for various other paraphilias demonstrated success ranging from 80% (frotteurs) to 100% (zoophiliacs).

Addendum E:

Information about Sexually Abusive Juveniles:

Who are sexually abusive juveniles? Sexually abusive youth come from all socioeconomic backgrounds, all ethnic groups, all types of families, and from every kind of community. They are a heterogeneous mix of different types and characteristics (Bourke and Donohue (1996); Knight and Prentky (1999)). They differ according to victim and offense characteristics, types of offending behavior, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health problems (Knight and Prentky (1993); Weinrott (1996)). They range on a continuum from the naïve experimenter to the disturbed impulsive, from the developmentally delayed to the gifted, and from the charming sociopath to the criminally sadistic. This means that their treatment needs which can be very different and each will need the benefit of individualized planning.

The terminology used for sexual offenders varies greatly and from state to state. Some of the definitions are legal in origin and some are clinical. A universally accepted but simple definition is an individual who behaves sexually with another person without that person's consent. For treatment providers this is the most important definition. One can be sexually abusive without it falling under any legal qualification. The act is harmful whatever the legal definition may be.

We do know a great deal about juvenile offenders at his point that is very helpful. Having this information we can develop programs to target the specific problems and impact on those issues which have shown to be high risk factors for sexual offending and for reoffending.

- 86% of adolescent sex offenders committed a non-sexual offense as well as a sexual offense (Jacobs et al (1998)).

- 40% to 80% of juvenile sex offenders have been found to be sexually abused, and 20 to 50% have been physically abused. (Hunter and Becker, (1998), Kahn and Chambers, (1991)).

- Exposure to family violence is linked to the likelihood of sexually offending as an adolescent, as well as the severity of psychosexual disturbance (Fagen and Wexler, (1998)).

- Exposure to aggressive male role models, exposure to severe community violence may also increase the likelihood of engaging in violent and antisocial behavior (Johnson-Reid, (1998)).

- Sexually abusive juveniles have high rates of learning disabilities, the presence of behavioral problems, difficulties with impulse control and judgment. (Karvosi et al, (1991), Epps, (1991)).

- Four developmental antecedents of sexual aggression were found in a study of 81 sexual offenders: caretaker inconsistency, institutionalization, family instability and physical and sexual abuse and neglect (Prentky and Knight, (1998)).

- Domestic violence was reported in 47% of the families of sexually abusive youth, Richardson, et al (1997)).

- In a retrospective study of 51 families of sexually abusive youth, 25% lacked sexual boundaries, 33% reported the presence of pornographic materials. (Manucha and Mezey, (1998)).

- Barbaree et al, (1998) concluded that sexual offending is a result of childhood abuse, inadequate attachment, dysfunctional family and temperamental variables.

- Most common DSMIII diagnoses in sample of male juvenile sex offenders were conduct disorder (48%) and for juveniles who raped (75%) (Kavousrsi, Kaplan and Becker, (1997))

- Sexually abusive youth in residential programs had higher rates of hyperactivity or restlessness, depression and anxiety, fire setting, encopresis, early onset of neurological illnesses or conditions, learning disorders, and health problems than the non sex offending population. (Bagley and Schewchuck-Dann,(1991)).

- Substance abuse is identified as a problem for many juveniles who have sexually offended but the role of substance abuse is very unclear. (Miner et al, (1997)).

- The majority of sexually abusive youth are male, but there are significant numbers of sexually abusive females. A survey of 2,600 men and women revealed that women abused 18% of the abused subjects (Finklehor, (1990)).

- In a study of rapists abused in childhood (Burgess, et al, (1987)), 40 % were found to have been abused by females. In a Maine study (Righthand, Hennings, and Wigley, 1989); females represented 11 percent (40) of the 348 juveniles identified as sex offenders by the Maine Departments of Human Services and Corrections during a 12-month period between 1988 and 1989

- There are meaningful similarities and differences between female and male sexual offenders. The girls' offending behaviors were similar to the boys both in terms of types of offenses committed, and the tendency to victimize young children of the opposite gender. Girls, however, typically had more severe victimization experiences themselves and more severe mental health problems. Matthews, et al, (1997)).