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The Effect of Training On Referrals To An Outpatient Adolescent Sex Offender Treatment Program

by

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A thesis submitted in partial fulfillment
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in
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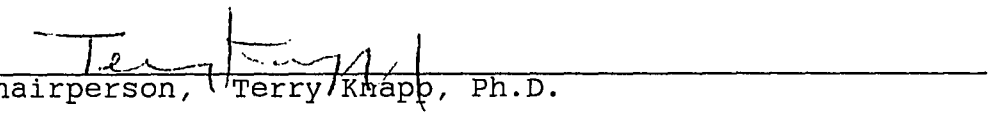

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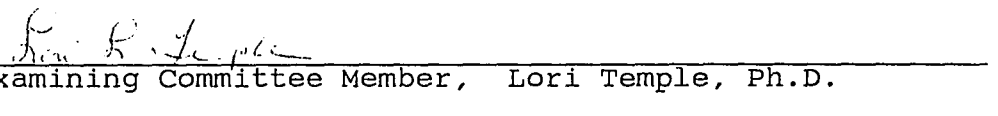

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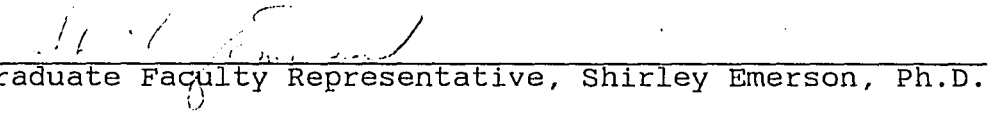

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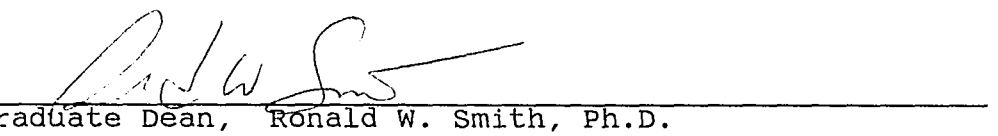

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Abstract

This study examines the effect of training on referrals to an outpatient adolescent sexual offender treatment program. Fifty-two juvenile court probation officers were trained to assess and identify adolescent sex offenders who met program referral criteria. Pre- and post-training tests were administered to measure the effect of training on a subject's knowledge and understanding of sex offender assessment. Utilizing the Juvenile Sexual Offender Decision Criteria Form (University of Washington, 1986), referrals before and following training were evaluated to determine if they met program criteria. Analysis of the data suggested that training improved subjects' knowledge and understanding, but not their ability to correctly identify adolescent sex offenders who met program referral criteria. Methodological problems, interagency differences, minimal treatment/referral options, and training inadequacies may explain the obtained results.

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Acknowledgements

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Finally, I would like to offer my gratitude to the the many professionals who have pioneered the field of specialized juvenile sexual offender services and, to the University of Washington for allowing me to use the Juvenile Sexual Offender Decision Criteria Form.

The Effect of Training On Referrals To An Outpatient Adolescent Sex Offender Treatment Program

Introduction

This study examines the effect of training on referrals to the outpatient adolescent sexual offender treatment program at Southern Nevada Child and Adolescent Mental Health Services (S.N.C.A.M.H.S.). Clark County Juvenile Court probation officers were trained to assess and identify adolescent sex offenders who meet the S.N.C.A.M.H.S. program referral criteria. The following topics are reviewed to illustrate the importance of training probation officers on juvenile sex offender assessment: 1) incidence rates for adolescent sexual aggression; 2) the intervention process for adolescent sexual offenders in southern Nevada; 3) characteristics of an adolescent sex offender outpatient treatment population; 4) guidelines for assessment of adolescent sex offenders; and 5) the need for specialized training for juvenile court probation officers.

Incidence of Juvenile Sexual Aggression

Historically, juvenile sexual offenders have not been held accountable for their acts. Clearly

exploitative and criminal acts were dismissed by a "boys-will-be-boys" attitude (Ryan, 1986) which interpreted these behaviors as experimentation or exploration. Over the past decade the criminal justice and human service communities have come to recognize that a substantial proportion of all sexual offenses are committed by individuals under the age of 18. Over 600 specialized juvenile sex offender programs are now operating in 47 states (Knopp & Stevenson, 1990).

Though the exact incidence of adolescent sex crimes remains unknown, several studies suggest that the problem is significant and widespread in our society. Becker, Cunningham-Rathner, and Kaplan (1986) cited the National Crime Survey for 1979 which indicated that 21% of forcible rapes were committed by adolescent males between the ages of 13 and 18 years of age. Furthermore, the Federal Bureau of Investigation's Uniform Crime Report noted that 20% of those arrested for sexual offenses in 1981 (excluding prostitution) were individuals 18 years and younger (cited in Davis & Leitenberg, 1987). Additionally, in 1983, 24% of all sex related arrests in the state of California were individuals under the age of 20; two-thirds of those were under the age of 18 (CYA Task

Force Report, 1986). Adolescent sexual aggression is grossly under-reported (Knopp, 1985), and sex offenses against children by adolescents results in even fewer arrests than do adult offenses against children (Groth & Laredo, 1981). The incidence of juvenile sexual criminality can not be accurately measured by victim crime reports alone (Knopp, 1985).

Research over the last ten years suggests that a large number of sexual offenses against children can be attributed to adolescents. Finkelhor (1979) conducted a survey of 796 male and female college students and found that 33% of the women and 40% of the men reporting victimization identified the molester as a male aged 10-19. Deisher, Wenet, Paperny, Clark, and Fehrenbach (1982) reported that in 42% of the cases of children treated at two sexual assault centers, the perpetrator was an adolescent. Showers, Farber, Joseph, Oshlins, and Johnson (1983) estimated that adolescents are responsible for over 50% of the boys, and 15-20% of the girls, who are molested.

In another study, Ageton (1983) surveyed a normative and nationally representative sample of 863 male adolescents between the ages of 13 and 19 to obtain information on attempted or completed sexual

assaults. Of these adolescent males, 4% reported committing one or more sexual assaults during the previous year, with the proportion by age range as high as 8% for 17 year-olds. Though the terminology in Ageton's survey has come under some criticism, and thus may overestimate incidence rates (Davis & Leitenberg, 1987), these figures are indeed striking.

Sexual offenses committed in adolescence may be the precursor to a life long pattern of sexual aggression. Nearly half of the adult sexual offenders in some studies began offending as adolescents (Abel, Mittelman, & Becker, 1985; Groth, Longo, & McFadin, 1982). The typical age of inception of sexually aggressive acting out appears to be between the ages of 12-16 years of age (Groth & Laredo, 1981). Whereas adolescents have averaged approximately 6-7 victims (Showers et al., 1983), adult sexual offenders who start in adolescence can be expected to average over 380 victims in their lifetime (Abel, Rouleau, & Cunningham-Rathner, 1986), an increase of 55 times in the number of victims. Sound legal judgment, competent treatment decisions, and early therapeutic intervention are clearly needed.

While treatment efficacy with adolescent sex

offenders has not yet been thoroughly researched, Knopp (cited in Bengis, 1986, p. 6) reports preliminary program results that suggest "early intervention and specialized treatment can have a major positive impact on client prognosis." From 1979 to 1986, of 100 offenders that completed the Juvenile Sex Offenders Program at the Hennepin County Home School, only three have been known to have committed a sexual offense since release. Of 200 sex offenders who completed the Program for Healthy Adolescent Sexual Expression, seven subsequent sexual offenses have been reported. As of February 1986, it is known that approximately nine percent of adolescent sex offenders released from Echo Glen Children's Center, a Washington state juvenile corrections facility, have re-offended sexually (Kahn & Lafond, 1988). Becker, Kaplan, and Kavoussi (1988) report that a cognitive behavioral outpatient treatment program significantly reduced deviant sexual arousal (as measured by a penile plythesmograph) in a sample group of 24 adolescents who completed treatment. Studies documenting recidivism rates for untreated adolescent sexual offenders could not be found for comparison. However, as Kahn and Lafond (1988) state: "While it is premature to draw conclusions about actual

risk of re-offense, there appears to be some optimism about the effectiveness of treatment for the adolescent sexual offender" (p. 147).

During the past six years over 400 adolescents have been charged with a sexual offense in southern Nevada (see Table 1). Though no precise numbers are available, dozens of additional youth have come to the attention of the child protection, welfare and mental

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Insert Table 1 about here

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health systems, but they have not been formally adjudicated by the courts. If Nevada is like other parts of the country, it would be safe to assume that many more cases go unreported (Knopp, 1982).

Adolescent sexual aggression has become increasingly recognized by the juvenile justice and mental health systems as a serious and widespread problem. Many children and adults throughout the country are victimized sexually by adolescents each year. Sexual crimes by adolescents may be the precursor to a life-long pattern of sexual aggression. Early identification and treatment of adolescent sexual offenders may reduce the chance of future recidivism.

Table 1

Number of Adolescents Adjudicated for a Sexual Offense in Clark County, Nevada

	Number Adolescents Charged			
year	total	boys	girls	number of offenses
1984	62	62	0	122
1985	66	59	7	121
1986	87	85	2	286
1987	87	87	0	193
1988	68[a]	unk	unk	92
1989	56	unk	unk	unk
total	426			

Note. Complete 1988 and 1989 data unavailable.

[a] Number of adolescent offenders identified between July and December 1988 only.

Intervention Process

Sexual assault by adolescents is a community problem. The occurrence, investigation, prosecution, control and treatment of sexual assault fall under the jurisdiction of many different agencies, each with distinct missions and goals. These various agencies must be involved in the response to a juvenile who sexually assaults, to maximize the control of sexually aggressive behavior. No agency can effectively control or intervene singlehandedly; therefore an interagency, interdisciplinary approach to sexual assault intervention must take place (National Task Force Report, 1988).

The intervention process can be broken down into three major stages (National Task Force Report, 1988):

1. Legal Response - Reporting, Investigation, and Prosecution: This stage includes disclosure and reporting of the offense, protective services and/or law enforcement investigation, prosecution and defense, and case disposition (sentencing).
2. Assessment, Evaluation and Placement: This stage includes sex offense specific risk and clinical assessment, treatment and placement recommendations. Community safety, security,

supervision, and monitoring are all considered.

3. Treatment: This stage includes a variety of treatment modalities including sex offense specific treatment groups, psychoeducational groups, family and individual therapy. Treatment can occur in an outpatient, residential, inpatient or correctional setting. Community safety, supervision and monitoring continue to be considered throughout treatment.

In southern Nevada, the legal response begins when a sexual assault is reported to Clark County Juvenile Court Protective Services (intrafamilial abuse cases) or local police departments in Henderson, Las Vegas,and North Las Vegas (extrafamilial abuse cases). These agencies are responsible for investigating all sexual assault cases, including cases involving juvenile sexual offenders, and then forwarding the information to the District Attorney's Office for prosecution.

If the District Attorney decides an adolescent is to be prosecuted for a sexual offense, then a Juvenile Court Officer will be required to gather collateral information on the juvenile's background; social/ developmental/academic history, criminal behavior record, medical history, and clinical/psychological and

treatment history. This information will be used in the prosecution, evaluation, and disposition (sentencing) of the case. The officer will document this information in a report to be presented to the court during the disposition phase of the legal process. The officer is responsible for developing recommendations regarding disposition of the case, including, but not limited to: diversion programs, deferred sentencing, probation, supervision, placement, incarceration, and/or treatment.

Specialized assessment and treatment services for adolescent sex offenders are extremely limited in southern Nevada. Since 1986, Southern Nevada Child and Adolescent Mental Health Services (S.N.C.A.M.H.S.) has been the primary local resource for sex offense specific evaluations, and the only resource for peer group treatment. This state financed, community based outpatient treatment program is part of a larger outpatient department in a comprehensive mental health center. Two specially trained therapists (the researcher/author is one) work with the adolescent sexual offenders in the program, where services include specialized sex offense specific evaluations, a weekly adolescent sex offender/peer treatment group, and

individual and family therapy. The goals for each client of the S.N.C.A.M.H.S. outpatient sex offender program are summarized by the National Task Force on Juvenile Sexual Offending (1988) as: "1) to stop all sexually offending behavior, 2) to protect members of society from further sexual victimization, and 3) to prevent other aggressive or abusive behaviors which the offender may manifest" (p. 24).

Interagency cooperation and coordination is necessary to effectively govern all phases of the intervention process with adolescent sex offenders. Specialized assessment and treatment programs, an important component in the intervention process, are limited in southern Nevada. Training juvenile probation officers to more effectively utilize the assessment and outpatient treatment services at Southern Nevada Child and Adolescent Mental Health Services may expedite and enhance service delivery.

Outpatient Treatment Populations

No empirically validated criteria exist which clearly identify those adolescents that can be safely treated on an outpatient basis. Admission criteria among the more established outpatient programs are however very similar. The S.N.C.A.M.H.S. outpatient

sex offender program admission criteria are consistent with other outpatient programs.

Most outpatient programs suggest that acknowledgement of the offense, court involvement and supervision, and adequate family supervision and support are critical to treatment success and community safety (Knopp, 1982 and 1985; O'Brien & Bera, 1986; Saunders and Awad, 1988; Stickrod, Hamer, & Janes, 1984). All referrals to the S.N.C.A.M.H.S. program require the adolescent be formally adjudicated on a sexual offense, with a court order for sex offense specific therapy for the offender and the offender's family. Most outpatient programs eliminate sexual offenders who are very aggressive and violent, psychotic, psycho-pathologic, sadistic, ritualistic, compulsive, impulsive, or actively abusing drugs or alcohol (Knopp, 1982; 1985; O'Brien & Bera, 1986; Saunders & Awad, 1988; Stickrod et al, 1984). Groth, Hobson, Lucey, and St. Pierre (1981), found that outpatient treatment is most appropriate when: 1) the sexual offense did not involve the use of force and did not pose risk of physical injury; 2) the sexual activity did not involve bizarre or ritualistic actions; 3) it was a first offense, with no history of

chronic antisocial or violent behavior; 4) there is no evidence of serious psychopathology (e.g., psychosis, retardation, addiction, organicity); 5) the offender acknowledges the offense, is motivated for treatment, and is subject to dependable supervision of daily activities; 6) the offender has adequate social, intellectual, and psychosocial resources to meet the demands of daily living; and 7) there are dependable treatment and support services available in the community. All the above mentioned conditions have been incorporated into the S.N.C.A.M.H.S. outpatient sex offender program admission criteria.

A majority of juvenile sexual offenders show significant impairment in major areas of their functioning (Saunders & Awad, 1988). Denial is an issue with most sexual offenders (Saunders & Awad, 1988; National Task Force Report, 1988), and their motivation for treatment is usually questionable. The Groth et al (1981) criteria suggest inpatient or residential treatment, rather than outpatient treatment, is most appropriate for the majority of adolescent sexual offenders. Saunders & Awad (1988) found that close to half of the adolescents in their sample were placed in either a residential treatment

facility, secure/locked placement, or specialized group home with a therapeutic component.

From January of 1987 (program start), until December of 1989, one hundred and seven adolescents were referred to the sex offender program at Southern Nevada Child and Adolescent Mental Health Services. Table 2 shows that less than half of the adolescents referred to and evaluated by the sex offender program at S.N.C.A.M.H.S. met the agency admission criteria,

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Insert Table 2 about here

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and less than one third were accepted into the outpatient treatment program. Many of the adolescents were rejected because they denied the sexual offense, denied a need for treatment, refused to cooperate and participate in treatment, were not formally adjudicated, were adjudicated on a non-sexual offense, did not complete the pre-intake paperwork necessary to schedule an appointment, or had a history that suggested risk to the community was too high to safely treat on an outpatient basis. Fifty-three percent of the referrals were assessed to be more appropriate for a residential, inpatient or correctional facility.

Table 2

Referrals to the S.N.C.A.M.H.S. Adolescent Sexual Offender Treatment Program: Correctness of Referral and Recommended Intervention

Categories	Number	Percentage
Referral Correctness		
Met Admission Criteria	50	46.73
Did Not Meet Admission Criteria	57	53.27
Total	107	100.00
Recommended Intervention		
S.N.C.A.M.H.S. Outpatient Treatment Program	31	28.97
Other Outpatient Treatment	19	17.76
Residential Treatment	35	32.71
Inpatient Treatment	7	6.54
Correctional Facility	15	14.02
Total	107	100.00

Note. Numbers reflect referrals between January 1987 and December 1989.

From initial intake and evaluation to program completion, treatment for an adolescent sexual offender in the S.N.C.A.M.H.S. outpatient program lasts approximately 18 months. During treatment community safety and prevention of sexual abuse is considered the highest priority of intervention in sexual offending, and takes precedence over any other conflicting consideration (National Task Force Report, 1988). S.N.C.A.M.H.S. therapists managing each offender case are in constant communication with the family, courts and other community professionals to insure that the adolescent is complying with probation and treatment requirements. Because the S.N.C.A.M.H.S. therapists have other duties within the agency, the program can effectively and safely serve only 8-12 adolescents and their families at any one time.

Given the number of adolescent sexual offenders adjudicated each year in southern Nevada (see Table 1), and referred to the S.N.C.A.M.H.S. program, there is usually an extensive list of offenders waiting for admission, with some offenders and their families waiting as long as six months for an evaluation or treatment services to begin. The National Task Force on Juvenile Sexual Offending (1988) recommends that

treatment "intervention should begin as soon as possible after disclosure of the offending behavior" (p. 25). Increasing demands for services for other behaviorally and emotionally disturbed children without corresponding program and staff increases primarily due to budget constraints, has made it impossible to allocate additional S.N.C.A.M.H.S. staff resources to reduce the waiting list for the adolescent sexual offenders program. If the number of inappropriate referrals to the program could be reduced, and the waiting list shortened, then services could be provided to adolescent sex offenders in a more timely manner.

Outpatient adolescent sex offender treatment populations can be distinguished from a non-outpatient population. Outpatient treatment is not considered safe or effective with the majority of adolescent sex offenders. Training juvenile probation officers to correctly identify and refer only those adolescents appropriate for an outpatient program, may reduce the number of inappropriate referrals to the S.N.C.A.M.H.S. program.

Assessment of Juvenile Sexual Offenders

A thorough assessment prior to sentencing and placement is essential for proper disposition of a sex

offender's case (National Task Force Report, 1988). Pre-sentencing assessments should address both clinical needs and "risk assessment," and should be conducted by the qualified sex offender therapist together with probation, child protective, law enforcement, prosecution and defense services (National Task Force Report, 1988). Risk assessment describes the possibility that an offender will re-offend, and thus be dangerous to others in the community or a placement. Because of the extensive waiting list at S.N.C.A.M.H.S., adolescent sex offender cases reach the disposition phase of the legal process months before an assessment can be started by the S.N.C.A.M.H.S. therapists. As a result, Clark County Juvenile Court officers are often the only professionals to assess risk prior to sentencing/court disposition.

There are currently no validated instruments or criteria to accurately predict risk for re-offense (Smith & Monastersky, 1986; National Task Force Report, 1988); however, there exists a wide range of clinical experience that can be referenced as a basis for current assessment decisions (Groth & Laredo, 1981; Ross & Loss, 1987; Saunders & Awad, 1988; Smith & Monastersky, 1986; Wenet & Clark cited in Knopp, 1982).

Groth and Laredo (1981) suggest that the following eight issues be explored during the assessment process: 1) difference in age between the offender and the victim; 2) social relationship between the offender and the victim; 3) type of sexual activity; 4) extent of persuasion, enticement, coercion to attain sexual contact; 5) persistence of sexual activity, i.e., frequency, compulsive or driven qualities; 6) evidence of progression in nature and frequency of sexual activity; 7) nature of fantasies that precede or accompany the behavior; and 8) vulnerability of the victims due to a particular handicap or disadvantage. Groth and Laredo further suggest that the offender's offense behavior be examined in regard to the offender's personality development and in the context of the offender's life and family situation.

The National Task Force on Juvenile Sexual Offending (1988) suggests that a comprehensive pre-sentencing risk assessment should consider the following:

1. Victim statements
2. History (including family, educational, medical, psychosocial, and psychosexual)
3. Progression of sexual aggressive behavior development over time
4. Dynamics/process of victim selection

5. Intensity of sexual arousal prior to, during and after the offense
6. Use of force, violence, weapons
7. Spectrum of injury to victim, ie., violation of trust, fear, physical injury
8. Sadism
9. Ritualistic process
10. Deviant sexual fantasies
11. Deviant nonsexual interests
12. History of assaultive behaviors
13. Chronic/situational factors
14. Sociopathy
15. Personality disorders; affective disorders
16. Attention deficit; post-traumatic stress
17. Behavioral warning signs
18. Identifiable triggers
19. Thinking errors (irrational thinking)
20. Locus of control
21. Ability to accept responsibility
22. Denial or minimization
23. Understanding of wrongfulness
24. Concern for injury to victim
25. Victim empathy, capacity for empathic thought
26. Family's denial, minimization, response
27. Substance abuse
28. History of sexual victimization, physical or psychological abuse
29. Family dysfunction
30. Parental separation/loss
31. Masturbatory patterns
32. Impulse control
33. Mental status/retardation/developmental disability
34. Organicity/neuropsychological factors

Ross, Loss and Associates (1987), and Wenet and Clark (1986) have each identified risk assessment factors comparable to those of Nicholas Groth and the National Task Force. Each have developed a rating scale to assist in the decision making process of determining risk. Ross, Loss and Associates identify

21 separate factors to consider (see appendix B) that can be rated on a scale of low, moderate, or high. The Wenet and Clark Juvenile Sexual Offender Decision Criteria Form lists 62 factors within three risk categories - low, moderate and high risk (see appendix A).

Each sex offense specific evaluation completed by the S.N.C.A.M.H.S. therapists follows the guidelines established by the National Task Force on Juvenile Sexual Offending (1988). Ross, Loss and Associates (1987) risk assessment interview format, and Wenet and Clark's Juvenile Sexual Offender Decision Criteria Form are both utilized when deciding level of risk and program admission. The evaluations/risk assessments require up to 18 hours to complete. Evaluation time is spent as follows: one hour to review all the pertinent records (police reports, court documents, other evaluations), approximately one hour of telephone coordination and consultation (often to validate and cross check information), six to eight hours of direct client contact, and one to two hours to write a report. Sometimes an additional four to six hours of psychological testing is indicated and included in the evaluation. An evaluation is expensive to both the

agency and the client, in time and money. Evaluation of inappropriate referrals wastes time and money, and delays (via waiting lists) the provision of services to those adolescents that can most benefit from treatment.

Adolescent sex offenders must be thoroughly assessed prior to legal, treatment and placement decisions. Evaluations should include an assessment of "risk." Thorough evaluations are costly and time consuming. Inappropriate referrals can significantly impact limited S.N.C.A.M.H.S. program resources.

Training Juvenile Court Probation Officers

In southern Nevada, law enforcement officers, prosecutors, probation officers and court workers are all involved in developing recommendations regarding placement, treatment referral and case disposition. Decisions and recommendations by these professionals often result in referrals to the S.N.C.A.M.H.S. adolescent sexual offender program, and in fact a majority of the referrals to the S.N.C.A.M.H.S. program come from Clark County Juvenile Court. These decisions can have a significant impact on both time and cost to clients and the S.N.C.A.M.H.S. program, and on the time waiting for an evaluation to be scheduled. Training Clark County Juvenile Court Officers to assess and

identify adolescent sex offenders accurately seemed necessary to reduce the number of inappropriate referrals to the S.N.C.A.M.H.S. outpatient treatment program, and lessen the waiting time for those adolescents who could be best served by the program. Clark County Juvenile Court officers are often faced with making pre-sentence/disposition recommendations without a thorough assessment having been completed. Risk assessment training would improve the officers' assessment skills, and help with pre-sentencing recommendations.

Bengis (1986) recommends that anyone who interviews adolescent sexual offenders should be trained specifically in interview techniques with sexual offenders, and investigation of these cases. The National Task Force on Juvenile Sexual Offending (1988) also stated that probation officers and court workers who supervise offenders during the assessment and treatment process require special training .

At a transfer of knowledge workshop focusing on the adolescent sex offender, and sponsored by the California Department of Youth Authority, Office of Criminal Planning (1987), specialists in the field of juvenile sexual offending noted training standards for

peace officers do not include mandatory guidelines for training sexual assault investigators. These specialists recommended changes in state law requiring training and certification of juvenile sex offender assessors.

Initial/orientation training and on-going staff development with law enforcement and juvenile probation/court officers improves job performance and service delivery. In a 1986 survey of forty juvenile probation departments across the nation on policies, operations and programs, a large majority of the departments required initial training and orientation for new staff, and ongoing training for all staff, to improve job performance (Bensinger, 1988). Juvenile probation departments that do not offer or provide training to juvenile probation officers often have serious problems. An in-depth look at problems with the juvenile probation services in New York City by the Citizen's Committee for Children of New York (1982), found that: 1) investigative procedures were inadequate; 2) children received only routine or inadequate supervision; 3) many cases received only perfunctory treatment and paper referrals, with no follow-up; 4) perfunctory procedures for referral of

children to residential placement; and 5) increased delays in processing individual cases. One of the major deficiencies noted by the Citizens Committee was the lack of training for new probation officers. The committee recommended a training course be developed and offered by experienced officers on the provision of services to children and youth. In a 1978 study sponsored by the Virginia State Crime Commission, Mays (1979) identified similar problems with juvenile services, and recommended that training for law enforcement officers in the handling of offenses committed by or against juveniles be expanded and improved, and additional training for intake officers in all court service units.

Adolescent sexual aggression is recognized as a serious problem requiring a multi-agency, multi-disciplinary intervention approach. Treatment needs outnumber the available programs in southern Nevada; thus many inappropriate referrals are being made to the outpatient treatment program at Southern Nevada Child and Adolescent Mental Health Services. Specialized training is required by all those involved in the assessment and disposition of adolescent sexual offender cases. A juvenile court probation officer's

job requires the officer to make recommendations regarding disposition, placement and treatment of adolescent sex offenders. Probation officers are responsible for the majority of referrals (appropriate and inappropriate) to the S.N.C.A.M.H.S. program. Since training can enhance the officer's job performance and potentially improve referrals to the S.N.C.A.M.H.S. program, specialized training on adolescent sexual offender assessment was indicated.

The researcher trained juvenile court probation officers on the assessment of adolescent sex offenders, and identification of those offenders who can be treated on an outpatient basis. Training was expected to improve the quality (correctness) of referrals to Southern Nevada Child and Adolescent Mental Health Service's outpatient treatment program for adolescent sex offenders, thereby reducing the number of inappropriate referrals, and referrals overall.

Consequently, the following hypotheses were developed:

1. That training would improve juvenile court probation officers' knowledge and understanding of adolescent sexual offender assessment.

2. That training would improve juvenile court probation officers' ability to correctly identify adolescent sexual offenders who met an outpatient treatment program's admission criteria.
3. That training would reduce the number of overall referrals to an outpatient treatment program for adolescent sex offenders.

Method

Subjects

Fifty-two probation officers from Clark County Juvenile Court voluntarily participated as research subjects. Three additional probation officers completed the training but did not give permission for pre- and post-test scores to be used in the research. Five more probation officers participated in all or part of the training, but did not complete the post-test. All subjects were fully informed as to the purpose of the research, and signed a permission form authorizing use of pre- and post-test scores. All officers completing the training received eight hours of Police Officer Standards Training (P.O.S.T.) credit.

The subjects averaged 12 years of experience as probation officers, with a range from 1 to 24 years. The subjects worked in a variety of settings within the court, including the detention facility, temporary protective placement/shelter, child protection services, and the intake and field supervision offices. Half the subjects had previous experience working with adolescent sexual offenders. Only nine of the subjects had previously received training specific to adolescent sex offenders.

Procedure

In accordance with recommendations by Bengis (1986) and the National Task Force on Juvenile Sexual Offending (1988), the training was provided by the researcher/author, who has specific experience in interviewing, evaluating, and treating victims and perpetrators of sexual abuse.

Officers, supervisors, and the training coordinator from Clark County Juvenile Court were consulted regarding the training procedure. They suggested that training be convenient for officers to attend, be 8 to 16 hours in duration, and meet Police Officers Standards for Training since officers are required to obtain 24 hours of P.O.S.T. certified training per year.

Two eight-hour training sessions were held in Clark County Juvenile Court's own training classroom, one morning and one afternoon, to accommodate different work schedules and increase the number of subjects trained. Each training session was divided into two four-hour days for additional convenience. Both training sessions were identical in content and presentation.

The training was P.O.S.T. certified and met Clark County Juvenile Court requirements which included: 1) a formal training agenda; 2) instruction by an "area" specialist; 3) requirements for completion (post-test); 4) maintaining an attendance record; and 5) providing staff with improved skills/techniques in their specialties. Each officer who completed this training received eight hours of P.O.S.T. credit.

Classroom instruction was selected as the training technique because it is convenient, cost effective, flexible, best suited for large groups of trainees, the most typical method of training (Broadwell as cited in Craig, 1987). Subjects were exposed to the same material, at the same time and in the same manner. Subjects could interact with each other and the instructor, and training could be provided by one instructor.

Classroom instruction was supplemented by overhead (visual) materials, handouts, and case example discussion. Overhead (visual) materials were utilized to highlight key points, provide consistency between training sessions/groups, and to keep the trainer and subjects focused. Handouts were used as additional visual training material, and so subjects had

references to use when making referral decisions following training. Case examples were used to stimulate thinking (Pigors, & Pigors as cited in Craig, 1987) and provide a practical reference point for using the assessment material presented.

The National Task Force on Juvenile Sexual Offending (1988) guidelines on adolescent sexual offender training were followed closely. Training content included:

1. Dynamics of juvenile sexual offending
2. Development of offending behavior
3. Victimology and offenderology
4. Development of sexuality
5. Assessment of juvenile sexual interactions
6. Denial systems which support sexual abuse
7. Child development information relevant to child victims and juvenile offenders
8. Goals and rationale for early identification and intervention with juveniles
9. Need for investigation and prosecution
10. Need for interagency approach and roles of team members
11. Interviewing techniques for victims and offenders
12. Risk and clinical assessment information

The training agenda was reviewed first, with anticipated benefits of training emphasized in an effort to enhance internal motivation to learn (Goad, 1982). Subjects were then presented an overview of the problem of adolescent sexual aggression, the goals and rationale for early identification and intervention

with juveniles, the need for investigation and prosecution, and the need for an interagency approach (National Task Force Report, 1988; Metzner, 1988).

Subjects were presented an overview on the dynamics of sexual aggression, victimology, and sexual offender typologies as described by Groth (1982), Groth and Hobson (1983), and O'Brien & Bera (1986). Common psychological defenses such as denial, minimization, repression, blame projection, etc. (National Task Force Report, 1988), and cognitive distortions commonly utilized by sexual offenders were defined and described in practical terms. A sexual assault cycle model (Lane, 1987), which describes a progression of thinking, attitudes and behavior that occurs prior to each sexual assault, was introduced. Several case examples were presented to facilitate the officers' understanding of the various dynamics and typologies.

Training on the second day focused on assessment issues and skills (Ross & Loss, 1987; National Task Force Report, 1988), risk assessment (Smith & Monastersky, 1986; National Task Force Report, 1988), and criteria for appropriate referrals of adolescents to the outpatient adolescent sex offender treatment program at Southern Nevada Child and Adolescent Mental

Health Services. An overview of treatment issues (National Task Force Report, 1988; Knopp, 1985) and the S.N.C.M.H.S. treatment program was also provided to help subjects further discriminate appropriate outpatient treatment referrals. Handouts included the Admission Criteria at Southern Nevada Child and Adolescent Mental Health Services (see appendix C), and the Juvenile Sex Offender Decision Criteria Form (see appendix A).

Skills training included the importance of a non-judgmental interview style, open ended questioning, specific questioning about entire range of healthy and deviant sexual behavior, and use of confrontation. Risk assessment focused on use of the Juvenile Sexual Offender Decision Criteria Form. Ross, Loss and Associates' 21 risk factors (see appendix B) were utilized to enhance understanding. Subjects were asked to present current or past adolescent sex offender cases they had encountered, then practiced as a group assessing the case using the risk assessment material presented, and determining appropriateness for outpatient referral. Subjects were cautioned that as yet these factors had not been empirically validated, that risk for re-offense can not be accurately

predicted (Smith & Monastersky, 1986); therefore risk assessment information could only be used in conjunction with a thorough investigation and/or evaluation to make an informed decision regarding placement and referral decisions (National Task Force Report, 1988).

Subjects were given a pre-test at the beginning of training, to measure their knowledge and understanding of the dynamics of sexual aggression, sex offender typologies, and sex offender assessment. At the completion of training, subjects were given a post-test to measure the effect of training on the officer's knowledge and understanding of the material presented.

Two similar tests were used, Tests A and B, to minimize test effects. Half the subjects in each training session took test A as the pre-test, and the other half took test B. Subjects then were given the alternate test as the post-test; B if A was taken first, and A if B was taken first. To protect subject's confidentiality, an identification or matching procedure was not utilized on the pre- and post-tests. Group pre- and post-test scores were compared to measure training effects.

Tests questions included a mixture of multiple choice, short answer, and case example items (see appendix D). Questions tested knowledge and understanding of sexual aggression dynamics, typologies, psychological defenses, treatment types, and risk factors. Case examples tested the subjects' ability to use the training material in making risk and referral decisions.

For six months following the training, January through June 1989, probation officers were asked to use the Juvenile Sex Offender Decision Criteria Form presented in the training sessions to assess all adolescent sex offenders being considered for referral to Southern Nevada Child and Adolescent Mental Health. Using this form, the probation officer rated the referred adolescent on the following: 1) risk level (low, moderate, or high); 2) prognosis/amenability of treatment outcome (good, fair, poor); 3) case disposition (outpatient, residential, inpatient, or correctional program); and 4) S.N.C.A.M.H.S. referral appropriate (yes, no).

Southern Nevada Child and Adolescent Mental Health admission criteria stipulate that "low risk" adolescent offenders are acceptable for referral to outpatient

services. If the adolescent was rated as "low risk", and other basic admission criteria were meet, then a referral could be made to the agency. The Juvenile Decision Criteria Form was to be submitted with other required court documents at the time of referral.

All adolescent sexual offenders referred to Southern Nevada Child and Adolescent Mental Health, from July 1988 to June 1989 (six months before and six months after training), were assessed by the researcher and an independent blind rater to determine if they were appropriate for referral to the outpatient adolescent sexual offender treatment program. The Juvenile Sex Offender Decision Criteria Form was completed on each offender to determine if the "low risk" agency admission requirement was met. The Juvenile Sexual Offender Decision Criteria Forms were completed following review of documentation provided by the officers with the referral - police/investigation reports, court disposition report, court and/or other psychological evaluations, school records, and previous court records. To maintain objectivity and eliminate possible bias effects, the researcher and blind rater did not review the Juvenile Sex Offender Decision

Criteria Form completed by the referring probation officer prior to making their own rating.

Since admission decisions regarding adolescent sexual offenders directly impacted the researcher's work at Southern Nevada Child and Adolescent Mental Health Services, blind raters were necessary to negate possible researcher bias. No other raters with similar training and experience to that of the researcher were available to participate in the project. A University of Nevada undergraduate psychology student volunteered to be a blind rater. He received college credit for his assistance in the research, and was trained similarly to the probation officers. A second blind rater, to counterbalance researcher and blind rater differences, could not be found.

The quality of referrals (number of correct vs. incorrect referrals) to Southern Nevada Child and Adolescent Mental Health six months prior to training was compared to the quality of referrals for six months after training. The total number of referrals to the agency pre- and post-training was also compared.

Results

Pre- and post-training test scores were compared using an independent t-test, to determine the effect of training on subjects' knowledge and understanding of sexual aggression and adolescent sex offender assessment. Pre- and post-training referrals to an outpatient adolescent sex offender treatment program were compared utilizing a Chi-square test for significance, to determine if quality or "correctness" of referrals improved, and if the overall number of referrals changed.

Subjects' post-training test scores improved by thirty-one percent (see Table 3). An independent

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Insert Table 3 about here

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t-test revealed a significant improvement in post-training group test scores over pre-training group test scores, t (107) = 13.91, $p < .001$. The two training groups varied only slightly on pre- and post-test scores. Pre-test group results included five scores from subjects that did not complete the training. Because pre- and post-test scores for each subject were

Table 3

Average Pre- and Post-Training Test Scores

Group	Average Test Score	Percent Correct	n
Pre-Training			
Group 1	12.71	39.7	28
Group 2	13.38	41.8	29
Mean Score	13.05	40.8	57
Post-Training			
Group 1	23.23	72.6	22
Group 2	22.97	71.8	30
Mean Score	23.08	72.1	52

Note. Total score of 32 possible on pre- and post-tests. Group 1 training held 12/8 and 12/9/88, and Group 2 training held 12/13 and 12/14/88.

not matched, the five additional pre-test scores could not be factored out of the pre-test group. However, when the five lowest scores are removed from the pre-test group, in effect increasing the mean pre-test score, measurable differences between pre- and post-test group scores remain statistically significant.

Twenty-five percent of the adolescent sexual offenders identified by juvenile court were referred to Southern Nevada Child and Adolescent Mental Health Services during the six months prior to the training (see Table 4). During the six months following the training, only thirteen and one-half percent of the adolescent sexual offenders were referred. This would suggest that training juvenile probation officers on proper assessment and referral of adolescent sexual

Table 4

Number of Referrals Pre- and Post-Training

Referral Group	Number Referred	Non-Referrals	Total
Pre-Training	17	51	68
Post-Training	5	32	37
Total	22	83	105

offenders reduces the number of referrals for outpatient services, as expected. However, a Chi-square test indicates the magnitude of this reduction was not enough to achieve generally accepted levels of significance, X^2 (1, $\underline{N}$ = 105) = 1.908, $p > .05$.

The Chi-square test also revealed no differences in the quality (correctness) of referrals of adolescent sexual offenders following training, X^2 (2, $\underline{N}$ = 22) = .8245, $p > .05$. Only one of the five adolescent sex offenders referred following training was considered correct by the researcher and the blind rater (see Table 5), with both the researcher and blind rater

Table 5

Correctness of Referrals Pre- and Post-Training

Referral Group	Correct	Incorrect	Maybe Correct	$\underline{n}$
Pre-Training	3	9	5	17
Post-Training	1	4	0	5
Total	4	13	5	22

Note. "Maybe Correct" column documents those referrals that the blind rater and researcher correctness ratings differed.

identifying the same "correct" case. However, Table 5 also illustrates that the researcher and blind rater differed on their assessments of the pre-training referral group. Only 3 of the 17 pre-training referrals were assessed as correct by both the researcher and blind rater, whereas 5 of 17 referrals were assessed as correct by only one of the two raters. The remaining nine referrals were assessed as not correct by both raters. Table 6 illustrates that the blind rater identified almost fourteen percent fewer correct referrals than the researcher.

Table 6

Comparison of Blind Rater and Researcher Ratings for Correctness of Referral

	Correct Referrals		
Referral Group	Blind Rater	Researcher	*n*
Pre-Training	4	7	17
Post-Training	1	1	5
Total	5	8	22
Percent of Total *n*	22.7%	36.4%	

When differences between raters are eliminated - a referral was considered correct if rated so by one of the two agency/research raters - 8 of 17 adolescent sex offenders referred prior to training are considered correct for referral (see Table 7). A Chi-square test still revealed no difference in the quality of referrals of adolescent sexual offenders following training, X_2 (1, $\underline{N}$ = 22) = 1.170, $p > .05$.

Table 7

Correctness of Referrals Pre- and Post-Training: When Rater Differences Are Eliminated

Referral Group	Correct	Incorrect	n
Pre-Training	8	9	17
Post-Training	1	4	5
Total	4	13	22

Three of the five (60%) post-training referrals to the S.N.C.A.M.H.S. program were made by two officers who did not attend the training. Two of these three cases were considered "incorrect". The two remaining post-training referrals were each made by a different

officer; both did attend the training. Neither of the two trained officers referred "correctly". The only "correct" post-training referral was made by one of the untrained officers. Since half of the officers who referred cases post-training, and 60% of the post-training referrals, were not subject to the independent variable (training), any inferences regarding the training effect on referral quality or quantity is suspect.

Examination of the sixty-two items on Juvenile Sexual Offender Decision Criteria Forms, utilized by blind rater and researcher to determine correctness of referrals, did not identify any key items that might distinguish a correct from an incorrect referral. However, several themes emerged that may have influenced the researcher's and blind rater's decisions.

An offender's willingness to accept responsibility and openly discuss his sexual behavior, and the parent's willingness to acknowledge their child's involvement and openly discuss family problems, appeared to improve the chances a referral would be found appropriate for outpatient treatment. Conversely, those offenders who denied the offense,

refused to discuss the offense in a non-defensive manner, and blamed others or circumstances, and lacked family support, seemed less likely to be identified as appropriate for outpatient services.

Though difficult to distinguish within police and court reports, empathy for the victim, and remorse for the harm done others, also seemed to influence the rater's decisions. Incorrect referrals seemed to show little empathy for the victim or others, and tended to present themselves as victims. These offenders failed to demonstrate an understanding of the exploitative nature of their offense, and often they did not believe they had done anything wrong. Their parents also tended to be protective and uncooperative with the authorities.

Violence, or lack thereof, also seemed to help separate incorrect from correct referrals. Those referrals found to meet admission criteria rarely utilized force, weapons, or violence in their offense. Pre training correct referrals rarely exhibited a history of aggression. The single post-training correct referral did have a history of violence. Incorrect referrals, pre- and post-training, were more likely to use violence during the sexual offense, and

had higher frequencies of physical aggression in their developmental history.

Self esteem/perception, social adjustment, and affective state also seemed to influence decisions. Correct referrals generally seemed to have difficulty fitting in with peers, and/or adjusting to new social situations. They were often described as immature and socially inadequate, tended to have few friends, and/or befriended younger children. They rarely described themselves in a positive fashion, and identified few personal strengths. Correct referrals were also more likely to exhibit signs of depression.

Incorrect referrals tended to exhibit signs of grandiosity in self descriptions, claim numerous peer age friends, and deny problems. Parents also viewed the offender in a positive light and denied problems, though in some cases the offender had experienced previous behavior problems at school, or had come to the attention of the juvenile court for a non sexual offense. Few "incorrect" offender referrals had identifiable depressive episodes in their history.

The subject's knowledge and understanding of adolescent sex offenders, as measured on pre- and post-tests, improved significantly as a result of training.

Training had no measurable impact on referral quality, and though fewer referrals were made to the outpatient program following training, the change did not occur at a statistically significant level.

Discussion

This study proposed to improve the quality of referrals to an outpatient treatment program by training juvenile court probation officers to accurately assess adolescent sex offenders, thereby reducing the number of program referrals overall. Analysis of the data suggested that training improved subject's knowledge and understanding, but not their ability to correctly identify adolescent sex offenders who met the referral criteria for Southern Nevada Child and Adolescent Mental Health Services outpatient treatment program. Post-training test scores were significantly better than pre-test scores, suggesting that the subjects' knowledge and understanding of juvenile sexual offender issues and assessment improved. However, during the six month period following training, referrals of adolescent sexual offenders to the S.N.C.A.M.H.S. program did not improve as expected. Fewer overall referrals were made to the program, but not at a statistically significant level. Several factors may explain the obtained results, including problems with the study's design, interagency issues, service availability, and assessment problems.

A number of methodological problems warrant discussion. The fact that half of the officers who referred 60% of the post training cases were not subject to training, may account for the lack of change in appropriateness of referrals. If the hypothesis of this study is in fact true, and the two untrained referring officers had participated in training, they may have accurately assessed the inappropriate cases and not referred them. Or these officers may have referred adolescent offenders more appropriate for the outpatient program. In either case, the results of this study might be altered significantly. To test the hypothesis of this study utilizing the same methodology, all probation officers who make referrals to the S.N.C.A.M.H.S. program would need to be trained. However, the lone correct referral was made by an untrained officer, so this hypothesis may be completely inaccurate.

More adolescent sexual offenders were identified by the courts during the six month period prior to training than during the entire twelve month period following training (see Table 1). Referral numbers during the previous four years (1984 - 1987) had steadily increased, then dropped in 1989 to the lowest

figure in the past six years. Even more disturbing was the discovery that less than half (24) of the 56 identified offenders were formally adjudicated. The reasons for these dramatic changes could not be identified by court personnel or the researcher, but clearly some other variable may have been operating during the data collection period that influenced the results. Future studies would need to be designed to control for unforseen variables, so that training results could be more accurately measured.

The design of this study did not provide adequate control over unknown variables occurring within the two separate pre- and post-data collection periods. A change in design may have more accurately tested the study hypothesis. Referrals from a randomly selected group of trained probation officers might be compared to referrals provided by a control group of untrained officers during the same period of time. Unknown variables would then influence both groups similarly, allowing for a more accurate analysis of training effect.

Pre- and post-training referral groups were small, making comparisons difficult. Training effects, if present, might be measurable if pre- and post-training

samples were larger. Uncontrolled variables that might adversely affect a small sample can be equalized somewhat within a larger sample. Factors or patterns that might discriminate how referral decisions are made (review of individual items on Juvenile Sexual Offender Decision Criteria Form) could possibly be identified in a larger sample. Data collection was limited to the six months pre- and post-training. Collecting data for a longer period of time may have increased the sample size.

The researcher and blind rater did not always agree on the "correctness" of a referral. Correctness is a subjective judgment made by each rater, and determined following a review of records and completion of the Juvenile Sexual Offender Decision Criteria Form. Raters' unique life experience affects both their perceptions and interpretations of information utilized in this study. These differences in rater's perceptions and decisions regarding correctness may have interfered with measuring training effects on referral quality/correctness. A design improvement for this study might be the inclusion of a third rater to resolve rater differences on questionable referrals.

Individual subject (probation officer) differences may have interfered with measuring training effects. Subjects pre- and post-test scores were the only data to change at a statistically significant level. However, subjects pre- and post-test scores were compared by group, and not individually, to protect the officers' privacy. As a result, individual subject differences that may have influenced pre- and post-test group scores could not be evaluated. The scores of subjects who took the pre-test, but not the post-test, could not be removed from the data base, potentially distorting the results. Individual differences as measured by the pre- and post-tests could not be examined for factors that may have biased subsequent referrals. A coding or numbering system could have been utilized to maintain officers' confidentiality while comparing individual test scores. Tracking each subject's pre- and post-tests, and subsequent referrals, may have provided valuable information as to what knowledge and/or skills that were trained, help an officer make accurate decisions regarding referrals of adolescent sex offenders. This design would allow pre- and post-test scores to be analyzed with a t-test for dependent samples (vs. independent samples type used in

this study), a tighter design that provides more powerful results.

Methodological problems alone do not adequately explain the obtained results. Juvenile Court's reasons and criteria for making referrals to an outpatient treatment program may differ from the treatment program's criteria. The S.N.C.A.M.H.S. program is concerned with identifying those adolescents who can be safely and successfully treated on an outpatient basis, and limiting services to only that population. Juvenile Court's priority, which historically has been rehabilitation, is placement of as many adolescent sexual offenders in treatment as is possible. The quality and quantity of referrals may not have changed because referral "correctness" was based upon the treatment program's, not juvenile court's, criteria and needs.

Because of the rapid growth in the identification of adolescent sexual offenders, treatment and placement needs far outnumber the available facilities/programs in southern Nevada. A recent national survey (Knopp & Stevenson, 1990) identified Southern Nevada Child and Adolescent Mental Health Services and one other outpatient practitioner as the only providers in

southern Nevada of sex offense specific treatment (per her report, this private practitioner now treats very few adolescent sexual offenders). Of the two local resources, the S.N.C.A.M.H.S. program provides the only sex offense specific peer group treatment approach. No other programs for adolescent sexual offenders, neither residential, hospital, or correctional, are identified in the survey. Ethical guidelines require the S.N.C.A.M.H.S. program to exclude those adolescents who can not be safely and effectively treated on an outpatient basis, even if no other services are available. However, Clark County Juvenile Court may refer inappropriate (moderate to high risk) adolescent sexual offenders to the S.N.C.A.M.H.S. program, because it has no other choice.

A comprehensive continuum of treatment services is needed to address the variety of needs of adolescent sexual offenders adequately and safely (Bengis, 1986; National Task Force Report, 1988). A comprehensive service delivery system would include the following options: 1) maximum security with sex offender-specific treatment; 2) inpatient psychiatric hospital units with sex offender-specific treatment; 3) locked/secure residential sex offender treatment

facilities; 4) unlocked/medium (staff) secure residential units or training schools with sex offender programs; 5) alternative community-based living environments (foster care, supervised apartments) and residential group homes with offenders attending outpatient sex offense specific treatment programs; 6) outpatient treatment groups and day programs (offender lives at home or with relatives or friends); 7) short term sex offense specific psychoeducational programs; and 8) post treatment support/aftercare services. If a continuum of treatment services was available in southern Nevada, and probation officers could refer moderate to high risk adolescent sexual offenders to a more appropriate residential or correctional programs, then inappropriate (moderate to high risk offender) referrals to the S.N.C.A.M.H.S. outpatient treatment program may decrease.

Design problems, differences in court and treatment program criteria, and a basic lack of services in southern Nevada for adolescent sex offenders still may not fully account for the lack of improvement in referrals. Initial court (pretrial) assessments are generally the least reliable (National Task Force Report, 1988) because the alleged offender

may not be telling the truth. The offender is often motivated to present in the most favorable light possible to the court, in an effort to reduce legal consequences. Referrals to the S.N.C.A.M.H.S. program often occur during the pretrial assessment period. As data continues to be collected by the court, and distributed to the referral agency, the court's impressions and assessment of the adolescent offender may change. However, it is rare for the court, given the lack of services locally, and the likelihood the adolescent will remain in the community, to rescind a referral for treatment. The court's mission remains rehabilitation, and some officers have reported a hope the adolescent may be accepted into treatment, even if they suspect or know the referral no longer meets admission criteria.

Until assessment tools are validated, caution must be exercised in representing the ability to predict future sexual offending behavior (National Task Force Report, 1988). No instrument, including the Juvenile Sexual Offender Decision Criteria Form used in this study, can accurately predict re-offense risk or treatment prognosis. Human (probation officer) judgment is still required when making referral

decisions, and regardless of training and/or experience, individual differences in judgment may account for variability in referrals decisions.

Finally, consideration should be given to possible flaws in the design and implementation of the training procedure. This study is based upon the researcher's assumption that juvenile court officers needed training. The officer's training "needs" were determined via an informal telephone survey of probation officers, court supervisors, and the court's training coordinator. Literature discussing training needs and content for specialists working with adolescent sexual offenders was reviewed to determine knowledge and skills required to reach an acceptable level of competence. The agendas and researcher notes from several training conferences on assessment of adolescent sexual offenders were also reviewed. While this method of needs assessment was relatively fast, inexpensive, and easy to execute, it is also imprecise. Rummler (cited in Craig, 1987) would argue that it is difficult to evaluate the relationship of training to output given this type of needs assessment. A systematic, objective, performance or task analysis would provide a more precise identification of required

job tasks, knowledge and skills, and link them to job performance. Performance or task analysis can focus training on specific trainee needs, and then training can be directly linked to performance and output (Rummler as cited in Craig, 1987).

Pre- and post-training test results confirm a significant improvement in subjects' knowledge. However, application of that knowledge did not improve. It is commonly understood that "practice" is important when developing and maintaining a new skill. While case examples were discussed during training to provide subjects with an opportunity to utilize (practice) the newly acquired knowledge, this may not have been adequate. Use of role-play assessment interviews may have provided additional skills practice for subjects, and developed a deeper understanding of the material through "active learning." Well designed role play experiences "create practical, transferable learning [experiences] that participants ... are likely to apply in their everyday lives," states Phyllis Cooke (cited in Craig, 1987, p. 440). Lack of practice may have contributed to loss of skill, and poor referrals to the S.N.C.A.M.H.S. program.

While the classroom method of instructing is

considered the most popular and effective training method by many trainers, it can also become the most ill used of all the possible training techniques (Broadwell as cited in Craig, 1987). Broadwell (1987) believes that bad training can occur as easily as good training. Subjects were required to complete a training evaluation for P.O.S.T. credit. The majority of the subjects rated the training as good or excellent, but a few were disappointed. For those few subjects who rated the training as fair or poor, the value of the material presented may have been lessened and not retained. If the "disappointed" officers were one of the four who referred an adolescent post-training, and they had not valued or retained the training material, then training may not have improved the quality of their referrals.

Although training did not appear to affect referral quality, and a variety of potential factors may guide referral decisions, training juvenile court officers to better understand and assess adolescent sexual offenders continues to be important. Clearly the problem of adolescent sexual aggression requires serious attention by the courts and community mental health/treatment agencies. Treatment services in

southern Nevada continue to be extremely limited. There are more offenders locally than can be treated by existing specialists. Juvenile probation officers who attended training, but did not make referrals during the data collection period, may have improved their assessment skills as a result of training. Some of these officers will assess and supervise adolescent sexual offenders in the future. The court must understand and provide specialized interventions to these adolescents, if it wants to fulfill its' mission of rehabilitation. Southern Nevada Child and Adolescent Mental Health Services will continue to provide sex offense specific treatment to adolescents, but like the court, it can not address the problem alone. Community awareness, education, and training may encourage others to become involved, and ultimately improve the service delivery system.

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Appendix A

JUVENILE SEXUAL OFFENDER

DECISION CRITERIA FORM

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April, 1986

Instructions: The following criteria are to be used as clinical guidelines in evaluating the juvenile sexual offender. The criteria relates to both risk as well as appropriateness of outpatient versus residential treatment.

Code "1" if item is true, "0" if item is not true, and leave blank only if information is missing.

LOW RISK

____ 1. First documented offense, without evidence of a developing pattern

____ 2. Offender willing to explore offense in a non-defensive manner

____ 3. Offender acknowledges and understands the negative impact of the offense on the victim (empathy)

____ 4. Offender willing to accept responsibility for committing the offense without blaming others or circumstances

____ 5. Offender is guilty and remorseful because of the negative impact of the offense on the victim

____ 6. Offender understands the exploitative nature of the offense and reasons for it's wrongfulness

____ 7. Offender admits to committing the entire offense for which he was charged

____ 8. Offender has healthy attitudes about sexuality

____ 9. Offender has no history of behavior disorder involving physical aggression

____ 10. Offender has adequate social adjustment, including presence of a peer support group and participation in peer group activities

____ 11. Offender has no history of behavioral and/or academic school problems

____ 12. Parents/guardians acknowledge and understand the negative impact of the offense upon the victim

____ 13. Parents/guardians hold the adolescent responsible for the offense without externalizing blame onto others or circumstances

____ 14. Parents/guardians acknowledge adolescent committed entire offense for which he/she was charged

____ 15. Family supportive of treatment and willing to become involved in therapy

____ 16. Family identifies problems within family unit and among family members other than the deviant sexual behavior of the offender

____ 17. Offender's family unit is functional

MODERATE RISK

____ 1. Offender has committed two or more documented offenses

____ 2. Discontinuation of offense behavior if/when victim showed distress

____ 3. Offender resists describing and exploring offense in a non-defensive manner

____ 4. Offender does not understand the exploitative nature of the offense or it's wrongfulness

____ 5. Offender minimizes the negative impact of the offense on victim (little empathy)

____ 6. Offender has little or no guilt or remorse because of the negative impact of the offense on the victim

____ 7. Offender externalizes blame for offense onto others or extraneous circumstances

____ 8. Offender minimizes extent of involvement in the offense, admitting to only part of the offense

____ 9. Offender resists participation in the evaluation without refusing altogether

____ 10. Offender has negative self esteem

____ 11. Offender has depressive symptomatology

____ 12. Offender has unhealthy attitudes about sexuality

____ 13. Offender has been a victim of sexual or physical abuse, though this has not been a chronic or repetitive pattern

____ 14. Offender has a history of behavior disorder involving physical aggression

____ 15. Offender shows poor social adjustment, including isolation from peers and few peer group activities

____ 16. Offender has history of behavioral and/or academic school problems

____ 17. Parents/guardian minimize the negative impact of the offense on the victim

____ 18. Parents/guardian externalize blame for offense onto others or extraneous circumstances

____ 19. Parents/guardians minimize extent of offender's involvement in offense, holding him responsible for only part of offense

____ 20. Parents/guardians are resistive to participation in the evaluation without refusing altogether

____ 21. Mother or father is a sexual offender

____ 22. Mother or father have been a victim of sexual and/or physical abuse

____ 23. Family unable to identify problems within family unit or among members other than the deviant sexual behavior of offender

____ 21. Family is dysfunctional in response to transient situational factors, such as life cycle changes or other crises

HIGH RISK

____ 1. Offender has been treated for commission of a previous sexual offense

____ 2. Offense was predatory

____ 3. Offense was ritualistic

____ 4. Offense was sophisticated, involving precocious knowledge of sexual behavior

____ 5. Offense resulted in physical injury to the victim

____ 6. Offense was associated with use of drugs or alcohol

____ 7. Offense involved violence, physical force, use of weapon, or threat to use weapon

____ 8. Continued offense behavior despite victim's expression of distress

____ 9. Evidence of progressive increase in the force used to commit repeated offenses

____ 10. Offender completely refuses to participate in the evaluation

____ 11. Offender completely denies the referral offense

____ 12. Offender engages in compulsive masturbatory fantasies involving deviant sexuality or offense behavior

____ 13. Evidence of thought disorder

____ 14. History of firesetting

____ 15. History of torturing animals

____ 16. History of chronic substance abuse

____ 17. Offender has been a victim of chronic and repetitive sexual and/or physical abuse

____ 18. Parents/guardians refuse to participate in the evaluation

____ 19. Parents/guardians deny that offender committed the offense

____ 20. Parents/guardians deny that offender has any psychosocial problems

____ 21. Offender's family unit is chronically dysfunctional

____ Code risk: (1) low risk, (2) moderate risk, (3) high risk

____ Code prognosis/amenability of treatment outcome: (1) good, (2) fair/moderate, (3) poor

____ * Code disposition: (1) outpatient treatment, (2) residential treatment, (3) inpatient treatment, (4) correctional facility

____ * Refer to S.N.C.A.M.H.S.: (1) yes (2) no

* these two categories added by researcher

Appendix B

Adolescent Sex Offender Assessment Factors

Amenability to Treatment Factors

1. Cooperation with the assessment/interview process
2. Honesty and self initiated disclosure
3. Personal responsibility for the offense
4. Response to confrontation
5. Internal motivation for treatment
6. External motivation for treatment
7. Non-offending sexual history and past victimization
8. Factors precipitating the offense
9. Other abusive or addictive behavior
10. School/employment stability
11. Social relationships
12. Family system strengths, level of pathology
13. Treatment history
14. Deliquency/incarceration history

Seriousness of Offending Behavior Factors

15. Degree of aggression/overt violence in offense
16. Frequency and duration of the offense
17. Sexual aggression history (length, nature, & progression)

18. Offense characteristics other than sexual aggression

19. Victim characteristics

20. Number of victims in relation to victim access

21. Current degree of access to victim, potential victims

** Factors number 2, 3, 6, 8, 10, 11, and 12 may be utilized to estimate an adolescent offender's long term response to treatment.

@ adapted from Ross, Loss and Associates (1987).

Appendix C

Southern Nevada Child and Adolescent Mental Health

Adolescent Sex Offender Treatment Program

Admission Criteria

1. Youth between the ages of 13 (or in the 7th grade) and 17 years; youth over 17 years of age will be assessed for admission on a case by case basis.

2. Male referrals only; female referrals will be evaluated for the purpose of offering treatment recommendations and alternatives.

3. Youth shall be charged and found guilty of one or more specific sexual offenses (per Nevada Revised Statutes on sexual assault and related offenses).

4. Youth shall be placed on one of the following statuses with Juvenile Court:
   a. pending final disposition; plea hearing completed and found guilty on sexual charge (will not be contested or appealed);
   b. on formal probation for a sexual crime, with an assigned probation officer;
   c. under formal supervision of the court for a sexual crime, committed to the Nevada Youth Training Center or Spring Mountain Youth Camp, with commitment suspended contingent upon active participation and successful completion of treatment; or
   d. under formal supervision of the court for a sexual crime, currently detained in the Third Cottage Program, or detention.

5. As part of the court order and/or probation contract, adolescent offender and parents/guardians are ordered to participate in treatment, to make satisfactory progress, and to comply with all treatment recommendations.

6. Referrals shall have a family resource, e.g., parents, foster parents, legal guardian, caseworker, group home parent, etc., who is willing to participate actively in treatment and comply with all treatment recommendations.

7. The legal guardian is willing to complete a financial statement, and be responsible for insuring that regular payments are made, even if the adolescent offender is required to make payments. Fees will be assessed for service based on the agency's sliding fee scale.

8. Referrals shall have the potential to function within or above the normal range of intelligence; determined by a psycho-educational evaluation and/or school records.

9. Referrals shall not exhibit emotional or behavioral problems so serious as to warrant treatment in a residential, inpatient hospital, or secure/correctional facility.

10. Referrals with a primary substance abuse problem must have completed a detoxification program (if appropriate) prior to evaluation and admission, and must participate in treatment specific to the substance abuse (AA, NA, CA, etc.) while involved in the agency treatment program. Periodic urinalysis may be required by the treatment program.

11. Referrals shall include those youth who would otherwise be acceptable for outpatient services, and are assessed in the low range of risk using a commonly accepted risk assessment protocol for adolescent sexual offenders (such as the Juvenile Sexual Offender Decision Criteria Form by Wenet and Clark, 1986). Of critical importance, and mandatory for admission:

a) adolescent offender admits to committing the offense for which he was charged, and accepts responsibility for the offense with minimal denial, blame projection, rationalization, or minimization present;

b) adolescent offender acknowledges and understands to some degree the negative impact of the offense upon the victim; offender expresses feelings of remorse or guilt for the harm done to others;

c) adolescent offender acknowledges and understands to some degree the exploitative nature of the offense;

d) adolescent offender is willing to explore the offense in a relatively non-defensive manner; is willing to participate actively in group, individual and family therapy; is willing to comply with the program's Treatment Contract, group rules, and other treatment recommendations;

e) parents/guardians must acknowledge the adolescent committed the offense(s) for which he was charged, and must be willing to hold the adolescent responsible for the offense(s) without externalizing blame onto others or circumstances;

f) parents/guardians must acknowledge and understand to some degree the negative impact upon the victim; and

g) family is supportive of treatment, willing to be involved, and willing to comply with all treatment recommendations.

12. Some adolescent sexual offenders are assessed to be in the moderate range of risk primarily do to offense history (victim characteristics, duration and frequency of offense) and opportunity/access to victim(s). If an offender meets the criteria for low risk on all other factors, and the offender is placed in a residential facility or other well supervised setting, referrals for outpatient treatment will be screened for evaluation acceptability on a case by case basis. High risk offenders will not be accepted.

NOTE: Cases accepted for evaluation may be denied treatment if the criteria are not met, or if available services are inappropriate. Treatment

does not begin until after the evaluation is completed, and the adolescent offender is accepted into the program. If the program is full, cases accepted for treatment may be placed on a waiting list, pending an opening. Some adolescents may be admitted into the program on a probationary status for a minimum of six months, with final acceptance contingent on participation and progress.

Referral Process

1. All referrals will be made to the Outpatient Department Intake Coordinator at S.N.C.A.M.H.S., 486-6100.

2. Parents/guardians must contact the Intake Coordinator to request an intake packet. The packet will be sent to them to fill out and return to the agency. The parent/guardian must identify that the services being requested are for an adolescent who has committed a sexual crime.

3. Copies of the following documents must be forwarded to the Intake Coordinator for all adolescent sexual offender referrals: police reports; victim, witness, and offender statements; summary of previous court history/record; court psychological report(s); school reports and evaluations if available; summary of services or reports provided by other professionals, if available; court disposition report, if completed; and a completed Juvenile Sexual Offender Decision Criteria Form (Wenet & Clark, 1986).

4. Once all the necessary documents are received, the case will be placed on a waiting list for adolescent sexual offenders pending evaluation. NO CASE WILL BE PLACED ON THE WAITING LIST FOR EVALUATION UNTIL ALL MATERIALS ARE RECEIVED.

5. Except in cases of agency determined emergency, no more than one new adolescent sexual offender evaluation will be started each week.

Appendix D

Test A

1. List three factors required for sexual assault/ exploitation to occur:

   1.

   2.

   3.

2. Typical maladaptive defense mechanisms often utilized by adolescent sexual offenders include: (check all that apply)

   ____ denial

   ____ disassociation

   ____ suppression

   ____ minimization

   ____ rationalization

   ____ sublimation

   ____ projection

   ____ identification with the aggressor

   ____ introjection

3. Though adolescent sexual offenders are found in many types of families, these families seem to share some unique commonalities. Two important ways offender families appear similar are:

   1.

   2.

4. Some adolescent sexual offenders can be successfully treated in an outpatient setting. Which of the following risk levels would support an outpatient program referral: (check all that apply)

____ low risk

____ moderate risk

____ high risk

____ low and moderate risk

____ all the above

5. Community safety is often a critical issue when making decisions about legal action, punishment, and an appropriate treatment setting. The most critical factors to be considered are:

1.

2.

3.

4.

6. Previous sexual victimization as a child appears to play a role in the development of aggressive and exploitative sexual behavior in adolescence. Though research findings are unclear, it is currently believed that approximately ____% of adolescent sexual offenders are also sexual abuse victims.

____ 15% ____ 35% ____ 50% ____ 85% ____ 98%

7. Following arrest for a sexual crime, if an adolescent sexual offender discloses that he/she was victimized sexually as a child for the first time, this information:

___ a) should effect legal and treatment considerations minimally

___ b) is probably a ploy to avoid consequences from the court

___ c) improves treatment prognosis significantly

___ d) suggests the court should emphasize treatment options over consequences

___ e) c and d

8. There are several treatment modalities typically available in an outpatient setting. The treatment modality of choice for most adolescent sexual offenders is:

___ a) individual therapy - because it will be easier to establish rapport with the adolescent

___ b) family therapy - because the focus is on the family's dysfunction, not just the offender's problem

___ c) group therapy - because crisis created by the confrontation of peers weakens maladaptive defenses

___ d) sex education group - because adolescent sexual offenders are misinformed about normal adolescent sexuality

___ e) all the above

9. Regardless of the type of therapy (individual, family or group) chosen, treatment must be:

___ a) provided by a therapist of the same sex

___ b) focus on suppressed anger

___ c) sex offense specific

___ d) long term oriented

10. The "type" of offender that is likely to fall into moderate or high risk categories - due to higher frequency of offenses, longer offense history, and use of force and/or threats is:

___ the immature, inadequate "undersocialized" child exploiter (gravitates toward young children)

___ the sibling "incest" offender

___ the "sexual aggressive" - uses sex to experience power through domination; typically involves use of forced threats or violence

___ the "naive experimenter"

___ the "sexual compulsive" - typically engages in repetitive sexually arousing behavior

11. There is a significant possibility that the _____ will become a life long pedophile.

___ sexual compulsive

___ disturbed impulsive

___ undersocialized child exploiter

___ sexual aggressive

___ pseudo-socialized child exploiter

12. To benefit from outpatient treatment, and to be rated in the low risk category, an adolescent sexual offender must at least be _____ motivated to commit to and participate in treatment.

___ internally

___ externally

___ genuinely

___ all the above

13. Which of the following is an example of minimization:

___ a) "all I did was touch her breasts" (victim reports same)

___ b) "I put my private part in her private part"

___ c) "she had been abused a lot more by her father"

___ d) "it wasn't my idea, it was the other guys" (two offenders involved)

___ e) (a) and (c)

14. Sexually aggressive behavior begins (on the average) by age ____ for most sexual offenders:

____ 8 yrs ____ 11 yrs ____ 13 yrs ____ 15 yrs

Following each vignette, rate risk level (low, moderate or high) and recommend the treatment setting (outpatient, locked inpatient, open residential, correctional facility).

1. Troy, age 15, was a victim of severe physical abuse at the hands of his stepfather, his mother's third husband. The mother was passive and often

suffered from physical beatings from her husband as well. Troy had a history of firesetting, theft, vandalism and truancy over several years. Very social and flamboyant, he took a 14 year old girl out on a date and when she refused to "go all the way," Troy slapped her and forced her to perform oral sex by threatening her with a screwdriver. When Troy released her, she made her way home and told her mother what happened. Troy was arrested later that evening by the police for sexual assault.

RISK: ____ low ____ moderate ____ high

TREATMENT
SETTING: ____ outpatient ____ open residential

____ locked Inpatient ____ correctional facility

2. Jerry, age 16, had no close peer relationships and only a few school acquaintances. He could be considered a loner, and he spent much of his time watching television and playing video games at home. He was well liked by his parents and was in no trouble at home and school. When playing outside he was often by himself or with considerably younger children. In the course of playing with younger children he became involved with them sexually and required fondling and oral genital contact as an initiation rite for membership in a club he had formed. No threats or force were used, but he did maintain secrecy with the children by telling then not to tell their parents. One of the children told a teacher and Jerry was arrested for lewdness with a minor.

RISK: ____ low ____ moderate ____ high

TREATMENT
SETTING: ____ outpatient ____ open residential

____ locked Inpatient ____ correctional facility

3. David, age 16, was a football player and a good student. His mother was a traditional homemaker and his father was often gone, working two shifts in a hospital. David committed a series of exposing incidents in front of high school girls near his school and was identified and arrested by police. In the course of the investigation and evaluation it was discovered that he had exposed himself numerous times to his older sister who kept it a secret and just yelled at him. The total offense history spanned a two year period. David's parents tended to minimize the impact of the offenses on the victims, and though they agreed somewhat reluctantly to have their son participate in treatment, they stated that they weren't sure they could participate in family sessions given the father worked so many hours.

RISK: ____ low ____ moderate ____ high

TREATMENT
SETTING: ____ outpatient ____ open residential

____ locked Inpatient ____ correctional facility

Test B

1. Previous sexual victimization as a child appears to play a role in the development of aggressive and exploitative sexual behavior in adolescence. Though research findings are unclear, it is currently believed that approximately ____% of adolescent sexual offenders are also sexual abuse victims.

   ____ 15% ____ 35% ____ 50% ____ 85% ____ 98%

2. Community safety is often a critical issue when making decisions about legal action, punishment, and an appropriate treatment setting. The most critical factors to be considered are:

   1.

   2.

   3.

   4.

3. The "type" of offender that is likely to fall into moderate or high risk categories - due to higher frequency of offenses, longer offense history, and use of force and/or threats is:

   ___ the "undersocialized" child exploiter - gravitates toward young children

   ___ the sibling "incest" offender - molests within the family

   ___ the "sexual aggressive" - uses sex to experience power through domination

   ___ the "pseudo-socialized" child exploiter - gains sexual pleasure through exploitation of a vulnerable child

   ___ the "sexual compulsive" - typically engages in repetitive sexually arousing behavior

4. Though adolescent sexual offenders are found in many types of families, these families seem to share some unique commonalities. Two important ways offender families appear similar are:

   1.

   2.

5. There is a significant possibility that the _____ will become a life long pedophile.

   ___ sexual aggressive

   ___ naive experimenter

   ___ pseudo-socialized child exploiter

   ___ sexual compulsive

   ___ undersocialized child exploiter

6. Which of the following is an example of blame projection:

   ___ a) "if she had said no, I would have stopped"

   ___ b) "the system just doesn't understand, she is making that stuff up about my using a weapon"

   ___ c) "my parents never really cared about me"

   ___ e) (a) and (c)

7. To benefit from outpatient treatment, and to be rated in the low risk category, an adolescent sexual offender must at least be _____ motivated to commit to and participate in treatment.

   ___ a) sincerely ___ c) externally

   ___ b) internally ___ d) (a) and (b)

8. There are several treatment modalities typically available in an outpatient setting. The treatment modality of choice for most adolescent sexual offenders is:

___ a) sex education group - because adolescent sexual offenders are misinformed about normal adolescent sexuality

___ b) family therapy - because the focus is on the family's dysfunction, not just the offender's problem

___ c) individual therapy - because it will be easier to establish rapport with the adolescent

___ d) group therapy - because crisis created by the confrontation of peers weakens maladaptive defenses

___ e) none of the above

9. Typical maladaptive defense mechanisms often utilized by adolescent sexual offenders include: (check all that apply)

____ reaction formation

____ minimization

____ repression

____ denial

____ rationalization

____ distortion

____ projection

____ identification with the aggressor

____ somatization

10. Regardless of the type of therapy (individual, family or group) chosen, treatment must be:

___ a) sex offense specific

___ b) focus on suppressed rage

___ c) short term oriented

___ d) provided by a therapist of the opposite sex

11. Some adolescent sexual offenders can be successfully treated in an outpatient setting. Which of the following risk levels would not support an outpatient program referral: (check all that apply)

____ low risk

____ moderate risk

____ high risk

____ low and moderate risk

____ all the above

12. List three factors required for sexual assault/ exploitation to occur:

1.

2.

3.

13. Sexually aggressive behavior begins (on the average) by age ____ for most sexual offenders:

____ 8 yrs ____ 11 yrs ____ 13 yrs ____ 15 yrs

14. Following arrest for a sexual crime, if an adolescent sexual offender discloses that he/she was victimized sexually as a child for the first time, this information:

___ a) suggests treatment prognosis is poor

___ b) should minimally effect treatment and legal considerations

___ c) is probably a ploy to avoid consequences from the court

___ d) suggests the court should emphasize treatment options over consequences

___ e) c and d

Following each vignette, rate risk level (low, moderate or high) and recommend the treatment setting (outpatient, locked inpatient, open residential, correctional facility).

1. Johnny is a 13 year old boy who had been asked to babysit a neighbor girl, age 5, named Nickey. Johnny had been babysitting for only a short time and the situation was still new to him. While there he discovered a Playboy magazine hidden under the couch and Johnny found the explicit photographs arousing. While helping Nicky change into her pajamas, he wanted to see what it was like to kiss and touch the way depicted in the photographs. After a short time he felt guilty and stopped. Late that week Nickey told her mother and Johnny was arrested for lewdness with a minor.

RISK: ____ low ____ moderate ____ high

TREATMENT SETTING: ____ outpatient ____ open residential

____ locked Inpatient ____ correctional facility

2. Bill, age 15, was living with his father who had won custody of him and his sister after bitter divorce proceedings. He had grown up in a house where there was always tension and anxiety as a result of marital discord, and he generally learned to keep to himself. One day while taking the vacuum cleaner from his sister's closet, he turned to his sister who was sitting in her underwear and grabbed her, tore her underwear and attempted to mount her while she screamed "Stop! Stop!" Finally she pushed him off and he seemed to "come to his senses," grabbed the vacuum cleaner and left to complete his household chores. Because of the family tension the sister kept the event quiet.

   A second incident occurred with a girlfriend of his sister's, whom Bill accosted suddenly while ice skating with her, grabbing her breasts and buttocks. This incident was reported to the police and he was questioned and left to the custody of his father. He was finally arrested after accosting an adult female in the laundry room of his mother's apartment building. Again, the assault was sudden and unpredictable.

   RISK: ____ low ____ moderate ____ high

   TREATMENT SETTING: ____ outpatient ____ open residential

   ____ locked Inpatient ____ correctional facility

3. Norm was a 17 year old boy, the youngest of six children. He was an exceptional achiever: an A student and in the top bracket of students completing the SAT. This religious and college bound youth had also engaged in kissing, oral-genital sex, and penis-vaginal rubbing with a niece 6 years younger than he. The abuse events occurred regularly over a three year period and it appeared he had trained her into a victim role, and coaxed her to remain silent. Vaginal redness

led to questions by the girl's physician, and finally disclosure. The entire family was grievously shocked when Norm was arrested for lewdness with a minor.

RISK: ____ low ____ moderate ____ high

TREATMENT SETTING: ____ outpatient ____ open residential

____ locked Inpatient ____ correctional facility