Strengthening Community-Based Programming for Juvenile Sexual Offenders: Key Concepts and Paradigm Shifts

John A. Hunter
University of Virginia
Stephen A. Gilbertson
Wraparound Milwaukee
Dani Vedros
The Institute for Family Centered Services
Michael Morton
Norfolk Court Services Unit

The past decade has been witness to a sharp increase in residential placement of adjudicated delinquent youth, including juvenile sexual offenders. It is argued that this trend has fiscal implications and may be clinically contraindicated for less characterologically disturbed and dangerous youth. The authors advocate greater investment of public funds in the development and refinement of community-based intervention programs. It is believed that clinically and legally integrated programming, using newer social-ecological methodologies and supports, offers promise of reducing the number of youth who require residential placement, shortening residential lengths of stay and improving the transition of residentially treated youth back into community settings. Key concepts relevant to bolstering community-based programming for juvenile sexual offenders are identified and discussed. Two programs are described, and program evaluation data reviewed, in support of the viability of innovative community-based approaches to the management of this population.

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Court-ordered residential placement of adjudicated youth in the United States grew by 56 percent between 1988 and 1997, with out-of-home placement of juveniles committing so-called person offenses growing by 103% (Puzzanchera, 2000). In Virginia, the number of juveniles admitted to secure detention nearly tripled between 1986 and 2000 (Virginia Department of Criminal Justice Services, 2001). Surveys suggest that relative to residential care, community-based programming for adolescent sexual offenders decreased nationally from 81% of all programming in 1996 to 65% in 2000 (Burton & Smith-Darden, 2001; Burton, Smith-Darden, Levins, Fiske, & Freeman-Longo, 1999). These phenomena likely reflect both a national trend toward harsher legal sanctions for juvenile offenders and a dearth of community-based programming for adjudicated youth in many areas of the country (Hunter & Lexier, 1998).

At present, few states have community-based programs for juvenile sex offenders that are evenly dispersed across all of its regions and major population centers. This shortage, perhaps coupled with uncertainty about the safety and effectiveness of community management of sex offenders, has led a number of courts to rely on residential programming for treatment and containment of the population. The current article examines the prudence of this practice and encourages greater attention to the

establishment of complementary community-based treatment programs. It is argued that by strengthening community-based programming, states can reduce the number of juvenile sex offenders placed in residential care, shorten residential lengths of stay, and improve the postresidential transitioning of youth back into community settings.

The Need for Community-Based Alternatives

The need for viable community-based programming for juvenile sexual offenders is underscored by both economic and clinical considerations. With regard to the former, the cost of residential programming for juvenile sex offenders is generally several times that of community-based care and may substantially exceed $100,000 annually per youth (Hunter, 2002). Residential placement of ever growing numbers of youthful offenders can easily exhaust community and state resources. Furthermore, these burgeoning costs may progressively make it more difficult for states and communities to invest in community-based alternatives. Ultimately, communities and states may encounter budgetary constraints that limit the provision of comprehensive services to only a segment of the juvenile sex offender population in need of intervention.

Pertinent to clinical practice, recent research has demonstrated that the exposure of younger and less antisocial youth to older and more characterologically disturbed ones may produce enduring iatrogenic treatment effects (Dishion, McCord, & Poulin, 1999). These effects include increases in delinquent behavior, substance abuse, violence, and adult maladjustment (Dishion et al., 1999; Poulin, Dishion, & Burraston, 2001). Data, therefore, suggest that placing relatively treatable and less dangerous youth in residential programs with more seriously disturbed ones may permanently alter their developmental trajectories. Ironically, this may have the unfortunate consequence of actually increasing the risk that these youth will commit new sexual and nonsexual offenses. Overall, these data strongly support the contention that residential treatment programs should be judiciously used and reserved for more seriously disturbed and dangerous juvenile sex offenders.

Strengthening Community-Based Programming

Creating a better balance between residential and community programming in states across the country requires not only the development of more community-based programs but also the strengthening of community-based approaches to management of this population. Traditionally, community-based programming for juvenile sex offenders has consisted of placing these youth in sex-offender-specific group therapy, supplemented by family and individual therapies as deemed clinically appropriate. Juvenile sex-offender-specific group therapy typically involves providing all youth with some combination of the following: social skills and anger management training, sex education, confrontation and correction of cognitive distortions or thinking errors pertinent to sexual offending, strengthening impulse control, victim empathy work, and the teaching of relapse prevention (Hunter & Longo, in press).

Implicit in the above-described approach are several questionable and, as of yet, empirically unfounded assumptions. These include the assumptions that the general dynamics of sexual offending, and therefore the treatment needs, of most juvenile sexual offenders are the same; individual offenders are most effectively treated when placed in groups with other juvenile sex offenders who can confront and support them; treatment should be primarily focused on the sexual offending behavior and its presumed causes; and that sexual offending is largely a function of deviant sexual interests and social skill and cognitive processing errors that can be effectively addressed by clinicians in controlled, therapeutic environments (e.g., the therapist's office). The latter includes the assumption that changes observed in therapeutic settings are durable and that they generalize to other environments (e.g., home, school, community).

Although most clinicians working from the above model acknowledge the importance of family therapy with this population, this intervention is also typically provided in the therapist's office and usually involves little if any work with the youth and his or her family in the home or community settings. Similarly, limited attention is typically given to social and cultural determinants of the youth's behavior, in spite of growing evidence that these influences are important in understanding both the origin and maintenance of sexually aggressive and delinquent behavior (Eddy & Chamberlain, 2000; Hall, Sue, Narang, & Lilly, 2000). Although the described approach may be sufficient for the successful management of lesser disturbed and more motivated youths and families, it is often inadequate in addressing the problems of the high numbers of these youth and families who are more profoundly and pervasively troubled.

KEY CONCEPTS IN IMPROVING COMMUNITY PROGRAMMING

It is believed that the establishment of more effective community-based programming for juvenile sex

offenders requires attention to new research findings on this and related populations of aggressive and delinquent youth. It also necessitates reconsideration of how to best achieve effective interagency coordination in the planning and delivery of needed intervention services. Key concepts instrumental to programmatic revision are briefly reviewed in the following. This discussion is followed by description of two community-based programs that embody a number of these practices and theoretical influences.

Recognition of the Heterogeneity of the Population

Clinical observation and emerging research suggest that juvenile sexual offenders are a heterogeneous population, reflecting various types and levels of disturbance and risk of reoffending (Hunter, Figueredo, Malamuth, & Becker, 2003). Within the population, there may exist distinct juvenile sex offender subtypes with differential developmental trajectories. Some youth, especially those that acknowledge their offenses and are offending in association with psychosocial deficits, appear to be highly amenable to treatment. Others, including those who have persistent deviant sexual interests and/or characterological impairment, appear more dangerous and treatment resistant. These observations do not support the assumption that one size fits all when it comes to either legal or clinical intervention requirements.

Critical to the viability of community-based programming is early determination of the youth that can be most effectively and safely treated in a community environment. This requires an understanding of issues relevant to differential diagnosis and the use of assessment methodology that supports such determinations. Beyond the screening of youth for appropriateness for community-based care, there must be careful clinical attention to understanding the specific determinants of the youth's sexual offending and other maladaptive behavior. This understanding must guide formulation of the treatment plan and inform decisions such as whether he or she should be placed in group therapy and, if so, with what types of youth. Case conceptualization should also inform the formulation of therapeutic goals and decision making regarding where (i.e., in what environments) and who should deliver various interventions.

Establishment of a Seamless Continuum of Care

The heterogeneity of the juvenile sex offender population necessitates the establishment of a continuum of care. This continuum should be as seamless as possible. Historically, community-based and residential treatment of juvenile sexual offenders have been poorly integrated—youth are placed in one level of care or the other, each system independent of the other. Seldom have community and residential providers worked in tandem in the provision of assessment and treatment services. This lack of integration has likely negatively impacted clinical efficiency and costs.

A seamless continuum of care demands that community and institutional providers work in a cooperative and carefully coordinated manner. Community providers can play a vital role in screening youth for required level and type of care, especially when common risk and needs assessment methodology are used. This can expedite clinical decision making and facilitate the initiation of residential treatment services for those youth truly in need of residential placement.

When community and residential treatment programming share common treatment objectives and methods, community providers can provide needed adjunctive services to families during the course of the youth's residential stay. This is especially important and helpful when the youth's family resides some distance from the residential facility and frequent trips to the facility are impractical. Community-based programs can also provide needed transitional and aftercare programming to residentially discharged clients. To be maximally effective, these services should represent an extension (not replication) of the care the youth received while in residential placement. As such, they should be strategically focused in support of delineated relapse prevention goals and clinical objectives.

Shift Toward Social-Ecological Intervention Models

An ever growing body of research suggests that social-ecological models offer promise of improved clinical and costs outcomes with delinquent and aggressive youth (Borduin, 1999; Henggeler, Schoenwald, & Pickrel, 1995; Miller & Prinz, 1990; Zigler, Taussig, & Black, 1992). Social-ecological models are defined by their emphases on understanding delinquent behavior as a product of multiple, and oftentimes interactive, individual, familial, social, and cultural determinants (Borduin, 1999; Bronfenbrenner, 1979). Intervention requires the thoughtful conceptualization of how these influences produce and maintain maladaptive behaviors in each individual case and what is the best strategy for its alteration. Perhaps the best known and well-researched application of this theoretical approach is multisystemic treatment (MST) (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

MST has been assessed in a number of formal clinical trials and has consistently been found to be more effective than traditional approaches in attenuating delinquent and antisocial behavior in emotionally and behaviorally maladjusted youth (Henggeler et al., 1998). Furthermore, it has been shown to reduce hospital use and incarceration in high-risk populations and to lower costs of care (Henggeler, Melton, & Smith, 1992; Henggeler et al., 1999; Schoenwald, Ward, Henggeler, & Rowland, 2000).

As discussed by Henggeler et al. (1998), there are a number of differences in the MST approach relative to traditional care. These include the following: (a) interventions are provided in, and directed at, all relevant systems and environments (e.g., school, home, community, etc.); (b) interventions are present focused and action oriented and target sequences of behavior within and between multiple systems that maintain the behavior; and (c) although therapists play an important role in conceptualizing cases and developing treatment strategies, they may not be the agent that directly applies the intervention. As it relates to the latter, there is a particular emphasis within MST on empowering caregivers (e.g., parents, teachers).

Swenson, Henggeler, Schoenwald, Kaufman, and Randall (1998) discuss the special adaptation of MST to the treatment of juvenile sex offenders and preliminary research findings. Borduin and Schaeffer (2001) provide a research update on the application of MST to the treatment of juvenile sexual offenders. Formal assessment (i.e., randomized clinical trial) of a specialized version of MST for juvenile sex offenders is currently underway. This and future studies should help determine whether MST is more clinically and cost effective than currently popular, cognitive-behavioral approaches in treating juvenile sex offenders.

Broadening the Therapeutic Focus

To date, most juvenile sexual offender programming has almost exclusively focused on assessment and treatment of the youth's sexual behavior problem. Generally, there is little therapeutic attention given to the myriad of other problems these youth and families manifest. This narrowness of clinical focus is contradicted by the finding that psychiatric comorbidity in juvenile sexual offenders is high and that these youth appear to be at significant risk for engagement in other forms of delinquent and antisocial behavior.

Even in outpatient samples, nearly one half of juvenile sex offenders have been found to meet diagnostic criteria for conduct disorder (Kavoussi, Kaplan, & Becker, 1988). This rate is likely to be even higher in residential samples and in groups of youth who have engaged in rape of same age and older females (Becker, 1998). Mood disorders and substance abuse have also been found to be prevalent (Becker, Kaplan, Tenke, & Tartaglini, 1991; Hunter et al., 2003; Matthews, Hunter, & Vuz, 1997).

Inspection of program evaluation data suggests that rates of nonsexual recidivism in treated juvenile sex offenders are generally several times higher than sexual recidivism rates. Whereas rates of sexual recidivism are typically less than 15% in juveniles tracked 3 to 5 years following treatment, nonsexual recidivism rates range from 24% to 60% (Becker, 1998). Overall, the reviewed data strongly suggest that juveniles who have been referred for sexual offending frequently have problems that go beyond their sexual attitudes, cognitions, and behavior. It is, therefore, important that treatment programs conduct comprehensive assessments of these youth and conceptualize their intervention needs in a holistic and integrated manner.

Improving Integration of Legal and Clinical Management

Although many clinicians may agree that court supervision of juvenile sex offenders' treatment is vital (National Task Force on Juvenile Sexual Offending, 1993), collaborative clinical and legal case management too often consists of only the exchange of information via written progress reports and occasional telephone calls and face-to-face meetings. More rare is the direct involvement of probation and parole officers in the assessment and treatment processes and in clinical decision making.

It is believed that community-based intervention is most effective when legal and clinical professionals are functioning as a unified team (Center for Sex Offender Management, 1999). Trained probation and parole officers can actively participate in risk and needs assessment of newly adjudicated youths and along with clinicians can formulate disposition and treatment recommendations. Likewise, they can actively participate in the delivery of intervention services to these youth and their families. Probation and parole officers can also play an important role in assessing a youth's readiness for a return to the community following residential placement and his or her aftercare and placement needs. This includes participating in treatment team meetings prior to the youth's discharge from the facility, administering risk and needs assessment instruments in support of discharge planning, and helping determine the most

appropriate living environment for the youth on his or her return to the community.

TWO INNOVATIVE PROGRAMS

Wraparound Milwaukee

Wraparound Milwaukee, operated by the Child and Adolescent Services Branch of the Milwaukee County Behavioral Health Division, is a coordinated system of care for families of youth with severe emotional, behavioral, and mental health problems. The term *wraparound* refers to a collaborative, strengths-based model of family and community-centered practice anchored in ecological and systems theory (Malysiak, 1997). The emergence of wraparound methods applied to high-risk youth, including sexually aggressive youth, is reflective of a broader paradigmatic shift toward community-based, family centered, culturally competent, multisystem, and strengths-based alternatives to institutional and deficit-based care (Burchard, Burchard, Sewell, & VanDenBerg, 1993; Lyons, Mintzer, Kisiel, & Shallcross, 1998; Righthand & Welch, 2001; Stroul & Friedman, 1986).

The Wraparound Milwaukee program began as a cross-system collaborative pilot supported by a grant from the Substance Abuse and Mental Health Services Administration, under the Children's Comprehensive Services Grant Program. Milwaukee County was one of the first 11 communities to receive funding aimed at promoting fundamental changes in the delivery of mental health services to seriously emotionally disturbed children and their families. Following the pilot program's success in safely reintegrating 24 of 25 residentially placed youth back into community-based care (see Kamradt & Meyers, 1999, for description of outcomes), the program was expanded to serve as a care management organization for the entire county. In its present capacity, the program administers blended and flexible public funding to sustain a comprehensive array of carefully coordinated services and supports to families with youth of complex needs.

Beginning in 1998, all Milwaukee County youth deemed at risk for residential treatment because of complex emotional and/or behavioral needs are enrolled in the Wraparound Milwaukee continuum. Wraparound Milwaukee currently serves an average daily enrollment of 560 youth and their families, including between 65 to 70 adjudicated juvenile sex offenders. At present, rather than a judge unilaterally determining that residential treatment is the most appropriate disposition, placement and other treatment recommendations are generally deferred to the collaborative wraparound child and family team.

Funds administered by Wraparound Milwaukee are available for the provision of individualized services to families through the collaborative child and family team process, facilitated by a wraparound care coordinator. Care coordinators are mostly bachelor's-level workers who are intensively trained and certified in the wraparound process by Wraparound Milwaukee. Care coordinators maintain caseloads of no more than eight families. Care coordinators are not treatment providers; however, they are expected to knowledgeably broker services for families that match the needs and risks identified by the collaborative team. Weekly agency-based supervision, continuing education, and regular consultation with a licensed psychologist serve to broaden and hone the skills of care coordinators.

Wraparound Milwaukee has developed a fee-for-service provider network that includes more than 200 agencies and individuals offering a broad range of services and supports. Providers are representative of the cultural and racial diversity of the population served. Wraparound Milwaukee also operates a mobile urgent treatment team (MUTT). The team, comprised of three licensed psychologists and five clinical social workers, is available 24 hours a day to provide crisis intervention and support to the child and family team. Because of the implementation of Wraparound and MUTT, average annual publicly funded child and adolescent psychiatric hospital days for the served at-risk population has decreased from 5,000 to 200.

A team, including the probation officer and professionals providing specialized support services, conducts collaborative planning for delinquent youth. The cooperatively developed plan of care reflects needs across the multiple domains and contexts of the youth and family life. When the enrolled youth has engaged in behavior that represents a risk to community safety, individualized strategies prioritize public safety, hold offenders accountable, and strengthen relevant youth and family competencies.

Adjudicated Juvenile Sex Offenders in Wraparound Milwaukee

Wraparound Milwaukee takes very seriously the responsibility of providing for community safety when serving youth with a history of, or deemed at risk for, dangerous or harmful behavior. Adjudicated juvenile sex offenders are enrolled in Wraparound Milwaukee as a court-ordered condition of probation with the expectation that an appropriate level of offense-specific treatment and supervision will be provided to reduce risk and promote youth rehabilitation.

In January 2000, Wraparound Milwaukee began the implementation of enhancements to its juvenile sex offender programming with the assistance of a federal grant from the Corrections Program Office, U.S. Department of Justice. A policy team, which included representatives from the various systems involved in juvenile sex offender management, was formed to facilitate the collaborative program development.

Program activities developed as part of the grant project included the following:

- implementation of comprehensive data collection involving all youth referred to Milwaukee County Children's Court on a sexual offense;
- predisposition offense-specific assessment of youth and their families;
- predisposition offering of voluntary, offense-specific, multisystemic intervention with families affected by juvenile-perpetrated incest;
- cross-system training and ongoing consultation regarding best practices in juvenile sex offender assessment and treatment;
- ongoing evaluation of legal and mental health responses and outcomes;
- enhancement of existing postadjudication community-based, JSO programming; and
- development of community-based resources to support parents in providing supervision and structure for youth.

At present, decisions regarding treatment and level of supervision of sexually aggressive youth rely on initial (predispositional) and ongoing holistic assessment of youth and family strengths, needs, and risks (Gilbertson, Storm & Fischer, 2001). Training and community-based service promotion by Wraparound Milwaukee has resulted in the availability of a much broader array of legal, mental health, and community responses to juvenile sexual aggression. Matching interventions to identified youth and family risks and needs has largely taken the place of a generic one-size-fits-all approach to youth adjudicated of sexual crimes.

Population Served

Since 1995, Wraparound Milwaukee has served 245 males and 15 females adjudicated delinquents on sexual assault charges and deemed at risk of residential treatment. The average age of Wraparound Milwaukee adjudicated juvenile sexual offenders is 13 years 7 months; 68% are in 6th to 8th grade, and 54% have been identified as special education students. Sixty-seven percent of these youth are African American, 23% Caucasian, 9% Latino, and 1% Native American. Sixty-three percent are residing in single-parent (maternal) homes at enrollment; only 10% are residing with both biological parents. Annual gross family income is less than $15,000 for 44% and less than $25,000 for an additional 31%. The most common *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) diagnoses for Wraparound Milwaukee enrolled adjudicated juvenile sexual offenders are conduct or oppositional-defiant disorder (61%), attention deficit hyperactivity disorder (45%), depressive disorders (39%), and learning disorders (25%). Additional youth risk factors identified at intake include drug and alcohol abuse (26%), runaway behavior (24%), previous psychiatric hospitalization (23%), and suicidal behavior (11%).

Youth enrolled in Wraparound Milwaukee have often endured harsh life conditions. Many youth reside in impoverished and high-crime neighborhoods. Additional family risk factors identified at intake include substance-abusing caretaker (41%), abandonment by parent (38%), parental incarceration (32%), domestic violence (29%), neglect (17%), and parental severe mental illness (15%).

Victim and Offense Characteristics

The average age of sexual assault victims of adjudicated juvenile sexual offenders enrolled in Wraparound is 7 years 9 months. Seventy percent are female; 30% are male. Approximately 50% are a relative of the offender, 20% are child neighbors, 21% are peers, and only 3% are strangers. Sixty-eight percent of the offenses occurred in either the perpetrator and/or victim's home. In more than 60% of the cases, the victim was more than 4 years younger than the perpetrator. In 45% of cases, physical force was evident; however, no weapon threats have been found. For Wraparound Milwaukee–enrolled youth, touching victim's genitalia, (40%) and rubbing together of bare genitalia (23%) are the most common sexual behaviors resulting in adjudication. This is in contrast to those Milwaukee County youth receiving a correctional placement since 2000, for whom fellatio by the victim (47%) and penile-vaginal penetration (32%) were the most common behaviors resulting in adjudication. Twelve percent of those youth receiving a correctional placement used a weapons threat during the commission of the crime.

Program Outcomes: System Changes

Access to a more comprehensive and data-based understanding of Milwaukee's sexually aggressive youth, their victims, and their families has corresponded to a shift toward use of services that seem to better match youth and family needs. This shift in use

has resulted in a significant reallocation of monies spent to serve adjudicated juvenile sex offenders and their families in Milwaukee. More than 50% of all Milwaukee County youth adjudicated of sexual offenses in 2001 were enrolled in Wraparound Milwaukee. This percentage represents a marked increase from 9% during 1996 and corresponds to a decline in adjudicated juvenile sex offenders being committed to correctional institutions (19% in 1996; 12.5% in 2001) from Milwaukee County.

The overall cost per child per month for the care of adjudicated juvenile sexual offenders and their families within the Wraparound Milwaukee continuum dropped by 18% between 2000 and 2002. This change can be attributed to the broader implementation and use of offense-specific and holistic assessment, the development of viable and credible community resources, and the corresponding decreased reliance on residential treatment as the sole means for treatment and supervision.

A recent comparison of use and cost of services provided by Wraparound Milwaukee to adjudicated juvenile sex offenders from January 2000 to September 2002 is reflective of a significant shift toward less restrictive, community-based care. Of the 63 adjudicated juvenile sexual offenders currently enrolled in the program, only 8 are placed within a residential treatment center. The remaining youth are residing either at home (29) or within other community-based placements (e.g., treatment foster care [12] or group home [6]). Decisions regarding out-of-home community placement reflect ongoing collaboration between treatment providers, the court, and child or family service agencies in determining the safety needs of the victim and the supervision and service needs of the offending youth. The juvenile sexual offender is always initially removed from the home in sibling incest cases. Reunification of the offender with the family is contingent on therapeutic progress and on determination that the safety and emotional well-being of the victim and family will not be compromised (Chaffin & Bonner, 1996).

Comparing the first 9 months of 2000 and 2002, Wraparound Milwaukee achieved a 34% decrease in the average per-child per-month cost of residential care for enrolled adolescent sexual offenders. This was in spite of a 15% increase in residential fees during the same timeframe. Use of therapeutic group homes also dropped by 75% during this period, reflective of a shift away from segregating and creating shared living arrangements for high-risk youth.

To insure appropriate supervision and structure for adjudicated juvenile sexual offenders managed in the community, community and home-based services were more frequently prescribed during the aforementioned period. These included crisis one-to-one stabilization (up 72%), parent assistance (up 54%), and treatment foster care (up 38%). Offense-specific doctoral-level individual therapy (up 22%) and in-home family therapy (up 49%) were also increased. Access to community-based psycho-educational groups has also improved and now includes a parent-education and support-group component.

Victim needs and voices are amplified as part of the collaborative team process. Intrafamilial victim services are accessed through the Wraparound Milwaukee provider network. Treatment outcomes are measured via standardized clinical and offense-specific measures and shared, as appropriate, with the court. Additional prioritized outcomes are tracked for each youth and family through the child and family team process and have reflected broadly based positive outcomes for Wraparound Milwaukee enrolled youth and their families (Kamradt & Gilbertson, in press).

Access to residential care remains an option within the Wraparound Milwaukee continuum as deemed appropriate. Residential treatment occurs only in specialized settings; outcomes are carefully monitored, and lengths of stay have decreased to an average of less than 3 months. Residential providers are part of the child and family collaborative team and work with family members and community-based providers to insure a smooth and safe return to the community. Wraparound Milwaukee care coordinators persistently communicate the importance of maintaining a focus on strengths and on the development of competencies relevant to risk reduction.

Recidivism

Juvenile justice outcomes for youth enrolled in Wraparound Milwaukee are tracked through ongoing data collection in collaboration with Milwaukee County Children's Court. Beginning in January 2000, the sexual offense characteristics and relevant history of all adjudicated juvenile sex offenders are detailed at the point of court intake. Any arrest or adjudication, after Wraparound Milwaukee enrollment, is recorded and incorporated into recidivism statistics. To date, adjudicated sexual recidivism during Wraparound Milwaukee enrollment (N = 202) is 8%; nonsexual recidivism is 27%. The average length of enrollment for adjudicated juvenile sexual offenders in Wraparound Milwaukee is 16.5 months. Youth, 1 year following discharge from Wraparound Milwaukee (N = 100), have reoffended at a 2% sexual offense rate and at 23% for nonsexual offending.

A study (Driessen, 2002) retrospectively examined all Milwaukee County youth adjudicated of sexual

assault during 1996, prior to the full implementation of Wraparound Milwaukee. At 5-year follow-up, sexual offense recidivism was found to have occurred at a rate of 15.5%, whereas nonsexual recidivism had risen to 68%. Longer term examination of sexual offense behavior and recidivism for Milwaukee youth adjudicated in 2000 (and beyond) will allow for comparisons to the 1996 sample and should provide clues as to the impact of system and program changes on valued outcomes.

NORFOLK JUVENILE SEX OFFENDER PROGRAM

The Norfolk Juvenile Sex Offender Program served as the pilot site for the Virginia Department of Criminal Justice Services's Community-Based Juvenile Sex Offender Supervision and Treatment project. The project, supported by a grant from the Corrections Reporting Program of the U.S. Department of Justice, had as its primary objective the development and statewide dissemination of model community-based treatment programming for juvenile sexual offenders. The Norfolk Court Services Unit, under the supervision of the Deputy Court Services Unit Director, administered the program. The senior author served as a consultant to the program during the initial 18 months of planning and implementation and provided monthly clinical case consultation to program staff and affiliated community clinicians.

One of the unique features of the enhanced program is the extent of interagency involvement in program development and oversight. The program receives ongoing guidance and support from a community advisory board. Key stakeholders include a juvenile court judge, court service unit staff, a commonwealth attorney, a representative from the Norfolk Defense Bar, two juvenile sex offender treatment providers, victim treatment providers and the local rape crisis center, social services, and the Norfolk Public Schools system. The program also greatly benefits from the support of a specially designated family assessment and planning team. This city-sponsored oversight team reviews all juvenile sex offender cases receiving public funding and is further tasked with assessing the quality and efficacy of rendered treatment and supervision services.

The developed program reflects very closely coordinated and strategically implemented legal management and clinical intervention services to adolescent male sexual offenders and their families. The program serves male youth between the ages of 12 and 20 who have been placed on probation and parole and who are residing in the local community. Probation and parole officers work collaboratively with community treatment providers as part of a unified supervision and intervention team. In this capacity, probation and parole officers perform key assessments, consultations, and supervisory functions and actively participate in treatment planning and implementation. The integrated legal and clinical team jointly makes all critical case-management decisions.

The implemented treatment model represents a blend of social-ecological and sex-offender-specific interventions and methodologies. Treatment goals and interventions target relevant sexual and related behavioral problems and are driven by a diagnostic understanding of multisystemic factors associated with their development and maintenance. The diagnostic process begins after adjudication with a comprehensive psychosexual evaluation. A state-certified sex offender treatment provider conducts this evaluation in consultation with court staff. Formal risk, needs, personality, and family functioning measures are used in addition to clinical interviewing of the youth and family. Assessments are aimed at determining amenability to treatment and the appropriateness of community-based care. Following disposition, the integrated legal and clinical team conducts additional assessment directed at understanding environmental-support and risk factors. This includes scheduled and unscheduled visits with the youth and family in their homes and the community.

All clinicians serving the program use the same assessment instruments and adhere to the described treatment model. This uniformity in approach has helped invested community agents understand and gain confidence in the program. The training of juvenile court judges and related agency professionals in the assessment approach and treatment model has further contributed to the success of the program. Judges and other stakeholders have become informed consumers, capable of formulating cogent referral questions and of better assimilating diagnostic and treatment progress reports.

Using information derived from the psychosexual and court intake assessments, the treatment staff, in collaboration with the family and court service unit personnel, develop a structured safety, supervision, and treatment plan. This plan serves as a contract with the family and youth and explicitly delineates provided intervention services and expectations related to accountability, behavior, and treatment compliance. The decision to use one, some, or all of the following therapeutic approaches is collaboratively determined in treatment-team planning meetings. The available approaches are described below.

Individual therapy. This is prescriptive and provided by the certified sex offender treatment provider. It is used as a forum for addressing personal victimization, comorbid, and complicated family issues and for providing crisis intervention. It can also be used to address treatment compliance issues and reinforce didactic material presented in group therapy.

Family therapy. This is used for assessing and addressing family system issues that impact the youth and his functioning. These include those related to safety planning, boundaries, and creation of a family support network. The clinician, in conjunction with a master's-level family intervention specialist, facilitates these sessions. Probation or parole officers participate as deemed helpful.

In-home services. These are provided to most youth in the program by a master's-level family intervention specialist, working under the clinical supervision of the senior, state-certified treatment provider. These services are more intensive and specialized than traditional in-home or mentoring services and are strategically focused in support of specific clinical and legal objectives. Family intervention specialists provide treatment-focused activities, assignments and counseling sessions that help the youth and the family practice and perfect skills learned in other therapeutic modalities. The family intervention specialist conducts ongoing assessment of the family's strengths and needs and is collaboratively involved in the development of specific goal-oriented intervention strategies. This individual may also provide mentoring support and, when possible, serves as a cotherapist in family therapy sessions.

Sexual offender treatment group. This is the major therapeutic vehicle for imparting principles, values, and skills to juveniles who have engaged in sexual offending behavior. The group is both didactic and process oriented and focuses on changing cycles of behavior, addressing thinking errors, taking responsibility for one's behavior, enhancing empathy and awareness of victim impact, controlling sexual arousal, and teaching relapse prevention. A therapeutic focus is also placed on values and skills related to anger management and conflict resolution, impulse control, and development of healthy social and sexual relationships. This group includes a mixture of approaches, such as didactic presentation, role play, group process, and therapeutic assignments. Youths are carefully screened prior to placement in group therapy, with particular attention to character pathology, and sexual deviance. This information is used to determine the best group fit for a given youth, so as to minimize the risk of iatrogenic treatment effects.

Parents' or caretakers' group. This is a required service for caretakers of youth receiving treatment services. This group serves to integrate families into the treatment community and to provide them with the information and support needed to safely and effectively manage, monitor, and support their youth throughout the therapeutic process. The curriculum closely parallels that of the youth group but also provides parents or caretakers with an opportunity to address personal and familial issues. The certified sex offender treatment provider and a family intervention specialist facilitate this group. Probation or parole officers attend as needed.

Relapse prevention services. Specialized relapse prevention services are provided to youth returning to the community from residential placement. Treatment providers and parole officers work toward establishing collaborative networks with discharging facilities so that a sensible and safe transition of services can be accomplished. Building collaborative networks with discharging residential facilities has been a challenge for the program, but the process is viewed as necessary for quality community-based programming to be achieved.

Integrated Clinical and Legal Management

The shared philosophy at the Norfolk program is that quality community-based sex offender treatment is contingent on successful legal and treatment service coordination. The treatment team is committed to working cohesively in developing service plans and managing risk. Team members are invested in clear communication, consensus about treatment issues and approaches, and consistency in holding offenders and families accountable. This is achieved through ongoing communication and active collaboration, including weekly phone consultation; weekly or monthly case conferences; shared training, assessment, and treatment planning; crisis management; and discharge planning activities.

Probation and parole officers within the program provide enhanced legal supervision to youthful offenders. Supervision is intensive (usually two to four face-to-face contacts per week) and includes the formulation of a 24-hour supervision schedule. The frequency of supervisory contacts is risk adjusted and includes consideration of the nature of the reference sexual offense, its behavioral determinants, and the youth and family's response to intervention. Youth remain on enhanced supervision throughout the course of their treatment and aftercare and are randomly checked in their homes, schools, places of employment, and treatment settings. These contacts

provide court officers the opportunity to observe youth and to receive feedback about their adjustment from multiple community sources.

The goal of enhanced supervision is to assure that juveniles and their parents fully comply with court orders and adhere to the rules of probation and parole. Accordingly, supervision efforts are aimed at maximizing participation in juvenile sex offender therapy and services. A strong emphasis is placed on parental accountability and active engagement in the treatment and rehabilitation process. A system of graduated sanctions, which places emphasis on behavior management, is used to address noncompliant behavior prior to using more restrictive placements, such as detention centers, correctional centers, and residential placement facilities.

For parole supervision, an important and necessary aspect of the program is starting the transition from the juvenile correction center to the community 3 to 4 months prior to the youth's anticipated release. Parole officers gather all pertinent educational, vocational, and treatment records and begin the case staffing process to assure that the appropriate community services are in place before the youth is discharged. When possible, joint visits are made to the correctional facility by the parole officer and community-based treatment provider. These visits serve as an opportunity to collaborate with residential providers regarding the youth's aftercare needs and to conduct up-to-date needs and risk assessments. The visits also provide youth with the opportunity to meet community-based treatment providers and to ask questions concerning aftercare program requirements.

Preliminary Program Outcomes

Twenty-five youth participated in Norfolk's program during its first year of operation. Nearly three quarters were probation cases; the remainder were parole cases. The latter did not include youth who were still in confinement at the time of the study. Participating youth ranged in age from 12 to 19 at the time of clinical intake. The mean age of those on probation was 14.9; the mean age of youth on parole was 18.9. As expected, youth on probation were younger at the time of the reference for sexual offense than were youth on parole (13.6 years vs. 15.3 years). Fifty-two percent of these youth were African American, 36% were Caucasian, and 12% were another minority. A higher percentage of youth on parole committed their sexual offense against a peer or adult female (42.9% vs. 20%).

The majority of youth admitted to the program acknowledged all or some part of the sexual offenses of which they were convicted (87.5%) and took total or partial responsibility for the behavior (82.6%). As expected, denial was higher in probation than in post-institutional treatment parole cases. Slightly more than one half of youth on probation acknowledged everything that they had been accused of, in contrast to three quarters of those on parole. Data suggest that, when present, denial of the reference sexual offense decreased from the point of program entry to follow-up for nearly three quarters of the youth. Furthermore, improvement in attitude was seen in nearly half of the cases where less than full accountability for the sexual offense was present at intake.

Most youth were totally or mostly compliant with legal directives, although compliance appeared to be slightly higher in parole than in probation cases. Therapists rated the majority of paroled youth as compliant with clinical directives and treatment program requirements; however, nearly half of the youth on probation were viewed as noncompliant to some degree. In general, youth that complied with legal directives were also compliant with clinical directives. As expected, the youth's level of compliance with legal and clinical directives appeared to be linked to level of family support and parental compliance. Consistent with past research (Hunter & Figueredo, 1999), acknowledgement of the sexual offense and acceptance of responsibility for the offending behavior appeared to be associated with compliance with legal and treatment program requirements and positive program outcomes.

Seventeen (70.8%) of the youth were still in treatment at the time of follow-up.[1] Four of the youth (16.7%) had successfully completed the program; two (8.2%) were discharged for noncompliance with therapeutic directives or violation of probation or parole (e.g., aggressive behaviors toward females); and one (4.2%) was discharged for administrative reasons. With the exception of the latter case, all youth taking full responsibility for their behavior at intake were still in treatment or had completed treatment at follow-up. In contrast, half of the youth who took no responsibility for their sexual offense had been discharged for noncompliance with treatment or violation of probation or parole. No youth committed a new sexual offense from the point of enrollment in the program to follow-up (range 1 to 8 months); 20% committed a new nonsexual offense.

Qualitative study of the success of the study was conducted by interviewing key court and community stakeholders. Results showed a consensus regarding achievement of the following program goals:

- improved collaboration between clinical and legal communities;
- improved community supervision and surveillance strategies;
- improved decision-making;
- more focused and strategic use of in-home services and mentoring;
- increased community knowledge of juvenile sex offender issues;
- increased community knowledge of victims of sexual offenses;
- increased specialization and skills by probation or parole staff;
- vastly improved psychosexual evaluation process; and
- improved treatment practices, interventions, and ongoing assessments.

Costs

The cost of clinical care for youth on probation, inclusive of initial psychosexual evaluation, was $27,857 per year. The cost of treatment for paroled youth was $10,400 per year. Factoring in the cost of legal supervision for these youths raised costs to $37,232.60 and $19,775.60, respectively. Group-home placement increased costs by approximately $50,000 to $60,000 per year. The latter was not used for placement of youth on probation (more than 80% resided with parents or other family members); however, more than 70% of paroled youth were placed in a group home. As with the Wraparound Milwaukee program, out-of-home placement decisions were collaboratively made by mental health, legal, and social service professionals based on safety considerations and the monitoring and/or service needs of the offending youth. Although the observed costs of community-based care were not minimal, they were still well below the typical cost of private residential or correctional placement.

Conclusions and Recommendations

It is believed that greater attention must be given to the development of safe and effective community-based treatment programming for juvenile sexual offenders. The development of such programming offers promise of reducing a growing reliance on residential care for containment and treatment of the population and improving clinical and economic outcomes. It is suggested that the enhanced viability of community-based programming is contingent on shifts in clinical paradigm and in a greater willingness of clinicians to engage in active collaboration with legal professionals and allied service providers. As such, it represents a departure from traditional independent and office-based practice patterns.

The success of community-based programming for juvenile sexual offenders is also dependent on broad interagency planning in the delivery of integrated clinical, legal, and social services to these youths and their families. Key stakeholders must be trained and actively engaged in program planning and resource development, and strong community infrastructures must be developed to meet the varied and complex service needs of the described clientele. Program evaluation data suggest that programs based on the described model are clinically and cost effective and are enthusiastically supported by participating courts and public agencies.

NOTE

1. Program status data were missing for one youth.

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John A. Hunter, Ph.D., is a research associate professor in the Department of Psychology at the University of Virginia. He is widely published on the study of juvenile sexual offenders and sexual trauma. His current National Institute of Mental Health-funded research focuses on understanding major subtypes of sexually abusive youth and their presumed differential developmental trajectories. He serves on several editorial boards and national advisory committees concerned with the perpetration of violence and juvenile sexual aggression.

Stephen A. Gilbertson, M.S., is a Wisconsin licensed psychologist with more than 20 years of experience working with children, adolescents, and families. At present, in addition to his private clinical and consulting practice, he serves as the clinical program coordinator of services to high-risk youth and families enrolled in Wraparound Milwaukee. Consistent with the mission of Wraparound Milwaukee to improve access to community-based and outcome-oriented mental health services, he applied for and received a federal Department of Justice grant to improve Milwaukee County's approach to juvenile sexual aggression. He has facilitated system enhancements through cross-system collaborative planning and program evaluation that allow for ongoing examination of juvenile justice, child welfare, and mental health policies and of practices and their impact on victims, offenders, and families affected by juvenile sexual aggression. He has provided training and consultation locally, statewide, and nationally and has authored several professional publications. He is a board member of the Wisconsin Professional Society on the Abuse of Children, the Ruddie Memorial Youth Foundation, and the Partnership Council of the Bureau of Milwaukee Child Welfare.

Dani Vedros is a licensed clinical social worker and certified sex offender treatment provider practicing in Norfolk, Virginia. She is in private practice and also clinically directs community-based

treatment of sexual offenders. She has presented on her clinical work with juvenile sex offenders at several state and national conferences.

Michael Morton is deputy director of the Norfolk Court Services Unit and provides administrative oversight to the Norfolk Juvenile Sex Offender Program. He developed the Norfolk Court Service Unit's original grant application to the Virginia Department of Criminal Justice Services to establish a juvenile sex offender treatment program and oversaw the implementation of program enhancements under a subsequent award to the state from the U.S. Department of Justice. He has a master's degree in public administration from Old Dominion University.