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Moral Reasoning in Juveniles Who Sexually Offend

by Norbert Ralph
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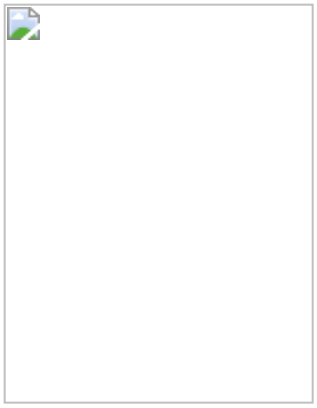

The establishment of a juvenile justice system, and Supreme Court decisions eliminating the death penalty, or life imprisonment for juveniles, is related to a view that adolescents are different in their thinking, motivations, and prognosis than adults regarding criminal behaviors (Steinberg, 2014). Developmental psychology and related research from brain development provide useful empirically grounded theories to understand the changes that occur in prosocial or moral reasoning during adolescence that have influenced the juvenile justice system. These developmental theories are as basic to understanding adolescence as the parallel biological changes regarding physical and sexual development. They are part of the universal biology of adolescence and basic to any work with this age group. As the body is changing physically and sexually, the youth's drives, interests, behaviors, and reasoning about life and relationships, including sexual issues, is developing. Just as we wouldn't want to treat medical problems of an adolescent without knowledge of adolescent diseases, anatomy, physiology, and growth, we are wise to be similarly informed regarding the best scientific evidence regarding developmental changes in prosocial reasoning and related areas in dealing with juvenile sexual offending. As described in this article, the developmental perspective provides useful and practical assessment methods for this population.

Youth on probation, including those who sexually offend, have engaged in some law violation which may be the result of deficits in prosocial reasoning. Therefore, tools to assess those deficits, and likewise interventions to promote prosocial reasoning skills would be beneficial to the field. The instruments to measure prosocial reasoning are closely related to clinical experience, provide objective measurement, and can be used to evaluate treatment outcomes. This contrasts with a style of clinical writing where developmental concepts are used as principles to organize clinical impressions and interventions, but without reference to the empirical measurement used to evaluate treatment outcomes.

A term used in this article, which may need clarification, is prosocial reasoning. Equivalent terms would be moral reasoning or social problem solving. Prosocial is the antonym of antisocial and refers to thinking and associated behaviors that promote desirable outcomes for the individual and others while following relevant laws and social norms. While the term antisocial usually describes "win/lose" interactions, prosocial refers to "win/win" interactions, where both parties benefit. To behave prosocially means the person is simultaneously tracking their own needs, while being aware of the needs and rights of others, and while being aware of

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the short and long-term consequences of behaviors, formal and informal customs, as well as rules and laws. Prosocial interactions with others which are mutually beneficial, in business or life, are usually the most advantageous, because they create the basis for future such relationships, without conflicts or adverse side effects. Also the term "juveniles who sexually offend" (JwSO) as used here describes behavior, not the person. Terms and words matter. The term "sex offender" implies a chronic behavioral pattern inconsistent with our understanding of these youth, especially given Caldwell's (2016) finding of a sexual recidivism rate of 2.75%. Finally, the research described below relates primarily to males, for a variety of reasons, including the lower prevalence of sexual offending among females, and far less scientific literature available.

This article will review relevant assessment tools for moral and prosocial reasoning, their utility with justice involved youth in general, and their application to JwSO specifically. Many issues are important to address with JwSO, such as the multiple consequences at home, school, family, and their life in general regarding their being on probation, and the stigma of their offense. Important areas may also include any prior victimization, school achievement problems, delinquent peer group issues, neighborhood and environmental factors, family dysfunction, substance abuse, and comorbid psychiatric issues. Prosocial or moral reasoning is proposed here as an additional factor to be considered as a focus of assessment and treatment with JwSO.

While bodies grow and develop from ages 10 to 25, so do the brains of adolescents, but in not so obvious ways. Although the size and major topography of the brain is largely complete at 10 years old, the interconnections and pathways of the brain continue to undergo major changes that continue past age 25. In the book,*The Teenage Brain* Jensen (2015) describes adolescent neuropsychological development. Major changes occur in pruning of neural pathways and myelination, while some brain regions continue to develop. There is a decline in gray matter and unmyelinated cells, with a concurrent increase in white matter. Jensen notes that the teen brain is only about 80% mature, and the outstanding 20% is the difference between adolescence and prosocial adulthood. Steinberg (2014) notes brain structure and functioning changes in adolescence are related to behavioral changes, and increased drive levels, and reward seeking generally, not limited to sexual interests. This is reflected in many ways, and one example is the predictable increase in all cultures of accidents in adolescence. This "accident spike" is complemented by a dramatic increase in sexual offending, with the highest incidence at age 14 (Steinberg, 2014). This is complemented by the increase in testosterone particularly in males during this period as well. Adolescents dramatically increase in size and strength, and after puberty have adult sexual capabilities regarding reproduction and function. Sexual drive is also increasing dramatically during this period. Typically the "eyes on" direct supervision for the average 12-year-old is far greater than for the 16-year-old. While impulse and drive, freedom, and abilities are increasing, judgment is still developing. If-then and cost-benefit thinking is a major area of growth during adolescence that is essential for the transition from adolescent to adult problem solving. Bonner (2012) describes early adolescence as a transitory developmental period, when youth are at high risk for committing illegal sexual behaviors that in no way reflect lifelong incurable sexual disorders.

With the rise of neuropsychology in the past 30 years, developmental theories related to prosocial reasoning have begun to be linked with brain functioning (Watson, 2002). Probably the best-known developmental theory with assessment tools related to prosocial or moral behavior is Kohlberg's theory of moral development (Kohlberg, 1984). Based on Piaget's work, moral development occurs in universal fixed stages where each stage represents a greater level of moral reasoning and complexity. Each stage defines the person's moral perspective and associated rules they use to govern one's behaviour. Kohlberg's theory describes six stages which can be grouped into three levels of two stages each: pre-conventional, conventional and post-conventional. The three levels and six stages are shown below and are adapted from Kohlberg (1984).

Kohlberg's Model of Moral Development

Level 1 (Pre-Conventional)
Stage 1. Obedience and punishment orientation
(How can I avoid punishment?)

Stage 2. Self-interest orientation
(What's in it for me?)
(Paying for a benefit)

Level 2 (Conventional)
Stage 3. Interpersonal accord and conformity
(Social norms)
(The good boy/girl attitude)

Stage 4. Authority and social-order maintaining orientation
(Law and order morality)

Level 3 (Post-Conventional)
Stage 5. Social contract orientation

Stage 6. Universal ethical principles
(Principled conscience)

A central dilemma in moral reasoning for any individual is how to get one's needs met, and accomplish individual objectives, without violating the rights of others, and associated social rules and laws. Without an internalized moral compass individuals are at risk for antisocial behavior. In the Kohlberg view, violating the law and others' rights is more likely to occur at the Preconventional Level. The person at these stages does not yet have an internalized view of social rules and laws as something that need to be followed, while simultaneously getting his/her own needs met. At the Conventional level, the individual is motivated by these internalized rules and Stage 3 and Stage 4 describe sequential steps in moral development. Older adolescents, and particularly adults who don't develop at a Stage 3 level, because of their increased size, strength, and decreased supervision by others, are at greater risk for antisocial behaviors. In what follows, the focus will be on the use of selected instruments of moral reasoning and relevant theories with juvenile populations. Their use with the general juvenile probation population will be discussed first, and then their use with JwSO.

The Kohlberg levels can be assessed using the Moral Judgment Interview (MJI; Kohlberg, 1984). This tool elicits answers to various moral dilemmas, which can then be reliably coded and classified according to the Kohlberg stages. While well researched, the Kohlberg MJI instrument takes significant time to complete, and uses examples unfamiliar to many youth. To address this, alternative measures were developed using the Kohlberg framework. One measure is the Sociomoral Reflection Objective Measure (SROM-SF; Basinger & Gibbs, 1987). The SROM-SF has two moral dilemmas and 12 questions. Respondents indicate which options reflect their own thinking, which are then scored according to the moral reasoning stages. Another measure is the Sociomoral Reflection Measure-Short Form (SRM-SF; Gibbs, Basinger, & Fuller, 1992). The SRM-SF contains 11 items which ask the respondent to evaluate and justify the importance of sociomoral values, including such concepts as contracts, truth, affiliation, life, law, property, and justice. Introductory statements are followed by questions, which require respondents to generate their own answers. Another instrument assessing the Kohlberg model is the Defining Issues Test (DIT) (Rest, Narvaez, Thoma, & Bebeau, 2000), which is a well-researched instrument for assessing moral reasoning. This approach examines what types of moral schemas are activated when individuals are presented with certain types of problems or dilemmas.

Other measures of moral reasoning are available. The How I Think Questionnaire (How I Think Questionnaire, n.d.) has been used to show positive outcomes in the EQUIP Program, designed to promote moral reasoning and decrease cognitive distortions in delinquent youth (Brugman & Bink, 2011). The Prosocial Moral Reasoning (PROM) is another instrument with a significant body of research that has been used to assess prosocial and moral reasoning in adolescents (Carlo, Eisenberg, & Knight, 1992; Siu, Shek, & Lai, 2012). An overall score provides an indicator of the developmental level of the respondent's prosocial reasoning. The Moral Judgment Test (MJT) (Feitosa, et al., 2013; Lind, 2015) assesses moral reasoning by examining how the subject deals with counterarguments to their views on difficult problems. The respondent rates statements regarding the story on a scale from *acceptable* to *unacceptable* on a nine-point scale.

Another instrument, not from the Kohlberg tradition, has been used to study moral or prosocial reasoning in youth on probation. The Roberts Apperception Test for Children-2 (Roberts 2; Roberts, 2005) involves showing pictures and asking the youth to make up a story that has several elements, including what was going on before, what are people thinking and feeling now, and what is the outcome. Its theory is developed from careful examination of responses of youth on this test and develops a conceptual framework to describe the changes that occur in thinking over time. It has well-documented and appropriate psychometric qualities. Responses can be interpreted as increasing levels of prosocial thinking and reasoning, which increased with age. Two scales especially relevant for assessing prosocial reasoning are problem identification and resolution. The Problem Identification scale measures the ability to identify problem situations, feelings and behaviors, prior circumstances, and internal processes. The Resolution scale similarly measures increasing levels of constructive problem resolution, which include the steps involved in solutions, and how relevant feelings are addressed in addition to the practical situation.

Similar to the developmental theories of Piaget and Kohlberg, successive levels of development in the Roberts 2 are characterized by increasing complexity and differentiation in responses. The Roberts 2 adds an important perspective to understanding moral or prosocial development during the teen years. In a previous publication (Ralph, 2012), I described how research identified that a difference between adults and adolescents is the use of "if-then" thinking regarding the "cost-benefit" calculation of situations. Regarding a hypothetical situation, such as riding a bike down stairs, compared to adolescents, adults are able to think through the upside versus the downside of such behaviors, and quickly make a decision. Adolescents have to think through the options, and use different parts of their brain compared to adults. Prosocial reasoning is not just a rule to be used, it's the ability to better understand the situation, its antecedents, people's motives, behavioral alternatives, and the likely consequences of behaviors.

Unpublished research was done by the author with the Roberts 2 using probation and normative samples (Ralph, 2007). The samples were matched for age and ethnicity, with 66 youth on probation and 68 youth from a nonclinical sample. The summary of the Problem Identification and Resolution scales was used as a measure to see if youth on probation could be differentiated from the normative sample, and indeed the AUCs were impressive for Problem Identification (0.92) and Resolution (0.88). In a separate publication, similar materials were used as part of a stimulus for a clinical intervention with youth on probation, to help elicit and enhance their social problem solving skills (Ralph, 2016b).

The research review up to now has been on youth on probation and prosocial reasoning. I will now review some of my research on JwSO youth specifically. The Washington University Sentence Completion Test (WUSCT) is a projective type instrument, which uses a sentence completion to assess the youth's level of ego functioning (Hy & Loevinger, 1996). This model and its stages very closely mirror's Kohlberg's levels of moral reasoning. This instrument's focus is on the individual's view of self, social relations, rules and values. It is a broader concept than the Kohlberg model of moral reasoning, but also includes it. It was hypothesized that this broader perspective more accurately reflected prosocial development in adolescence. The underlying hypothesis, generated from the Roberts 2 data, was that prosocial reasoning involves seeing the self, roles, and relationships in more complex ways captured by this instrument. The consequences of more complex development is the capacity for more prosocial behavior. Respondents can be assigned to one of eight levels of interpersonal maturity. Data is available for the WUSCT with JwSO from several male samples described in a previous publication (Ralph, 2015a). The first sample included 14 youth in a residential program for the treatment of sexual offenses. The second sample included 37 youth from outpatient and residential programs for sexual offenses. The samples were compared with a non-clinical group of 46 14-year-old males (Westenberg & Gjerde, 1999). Of the JwSO group, 92.5% were either classified as either Impulsive or Self-Protective (relatively lower levels of ego functioning), compared to 43% of the non-clinical sample. This finding is consistent with the research above indicating lower ego or moral reasoning levels among youth on probation. Although promising, there are a number of methodological limitations. The sample sizes are modest, and potential confounding variables such as SES, and verbal IQ, were not controlled in the comparisons. Replications with other samples with improved methodology would need to be done to have greater confidence in the results.

A newly developed instrument, the Prosocial Reasoning Outcomes (PRO), has been used with JwSO populations as well (Ralph, 2016b). The statistical analyses summarized here are described in greater detail in that publication. The PRO was influenced by both the Roberts 2, and the WUSCT regarding its general approach and theory regarding assessing youth on probation. It incorporates their approach of looking at the complexity of youth's view of social situations, and steps towards problem analysis and resolution as part of prosocial development. It is also more focused on prosocial reasoning specifically, which is easier to learn, test, and score. An assumption supported by existing research described above, is that youth on probation generally, and JwSO youth specifically, have delays in prosocial reasoning/ego functioning which may contribute to offending. Having adult type sexual abilities and drive, but with delays in reasoning compared to age-mates, in addition to other factors, may make these youth at greater risk for offending behaviors.

The PRO uses five vignettes and six follow up questions. There are a total of 30 responses, and each is scored as falling into one of three levels, shown below. Each successive level is seen as more complex than the one it proceeded, similar to the Roberts 2.

Level 1 Concrete: Simplistic or concrete description of feelings, rules, motives, outcomes, or consequences. Simplistic resolution of problems or feelings (e.g., "He is happy", "OK now"). Gratification of impulses is prominent, and also being overwhelmed, or helpless.

Level 2 Normative: Provides some context, contingencies, complexity, or alternatives. Perceiving and acting based on conventional rules, roles, and expectations of general society that are more than peer group values.

Level 3 Principled: Clear description of ambivalence, and alternatives, regarding feelings, rules, motives, outcomes, or consequences. Articulates concepts and/or steps regarding prosocial resolutions of problems and/or feelings.

Answers provide an indication of the level of prosocial reasoning of adolescents (ages 12 to 18). Research described elsewhere (Ralph, 2016a) uses the PRO to compare JwSO and non-probation samples. Two JwSO samples were used, all males, participating in either a High Level or a Medium Level program, based on risk level. In addition, a private high school population was used as a comparison group, 53% of which were males.

High JwSO Program (N=14)	Medium JwSO Program (N=30)	Private High School (N=30)
PRO average=1.74	PRO average=2.27	PRO average=2.73

The Prosocial Reasoning Outcomes showed that there was a statistically significant ranking between the various samples with respect to PRO scores (PHS>Med>Hi), as well as an age effect, in that older youth scored higher than younger youth, ($F(1,70) = 4.81$, $p = .03$) There was also an equivalent to a six-year difference between the Medium Level JwSO program, and the Private High School program.

A partial replication of the above study was conducted using a short version of the PRO, the PRO-S. It used the first vignette only. While the full version had 30 responses to score, the brief version uses six. A sample of JwSO from a treatment validation study was used, and this is described more extensively elsewhere (Ralph, in press). The sample consisted of 37 JwSO males in either outpatient or residential treatment programs, all of whom were on probation. The other sample used was the private high school sample (Normative) described above (n = 30). The average scores on the PRO-S for the JwSO and Normative groups respectively, were 2.28 and 2.83 ($F(1,68) = 15.72$, $p = .0002$). The difference between the two populations, similar to the findings with the full version of the PRO, may be due to other characteristics that differentiate the samples, including age, educational achievement, and SES factors. Replication of the findings would be necessary to have greater confidence in these results.

Stams et al. (2006), in a meta-analysis, summarize studies regarding juvenile delinquency and moral reasoning. It complements the research described above with JwSO. Stams et al. completed a meta-analysis of 50 studies using assessment measures of moral reasoning, including some discussed above, and found lower levels of moral judgment in delinquent youth than nondelinquent youth, with a large effect size (d=.76). They concluded that developmentally delayed moral judgment was strongly associated with juvenile delinquency,

even after controlling for socioeconomic status, gender, age and intelligence. They also distinguished between production and recognition measures and found that production measures produced a larger difference between delinquent and non-delinquent populations. They attribute this difference to the fact that the respondent is required to generate a moral reasoning response, rather than just recognize the right answer or desirable response. The Roberts 2, the WUSCT, the PRO, and PRO-S, described above would be classified as production measures.

In summary, there is significant evidence that prosocial or moral reasoning distinguishes youth on probation from non-clinical samples. There is also reasonable evidence that JwSO, similar to youth on probation, show differences compared to non-clinical youth. However, more research is needed to replicate and address methodological issues surrounding moral reasoning for JwSO. Specifically longitudinal designs may be useful as they allow researchers to measure moral reasoning along developmental gradients.

If moral or prosocial reasoning can help understand general and also sexual offenses, might it be modifiable and treatable? Aggression Replacement Training (ART) and Moral Reconation Therapy (MRT) are treatment methods for juveniles on probation that use a Kohlberg model of moral development. The effectiveness of ART with youth on probation is documented in a number of studies (e.g. Goldstein, Nensén, Daleflod, & Kalt, 2005). Amendola and Oliver (2010) reviewed ART evidence favorably, and noted that it is classified as a "Model Program" for the United States Office of Juvenile Justice and Delinquency Prevention, and the United Kingdom Home Office. Regarding MRT, Ferguson and Wormith (2013) reviewed 33 studies which showed a significant positive treatment effect size for adult and juvenile subjects. It is also listed as a Substance Abuse and Mental Health Services Administration evidence-based practice. Both ART and MRT are listed as beneficial practices for youth on probation by the Washington State Institute for Public Policy in their meta-analytic review (2016). Although there is emerging evidence to suggest ART is effective for JwSO (Ralph, 2012; Ralph, 2015a; Ralph, 2015b), additional and more rigorous evaluations are needed. To this end, it would be important to assess youth in various types of treatment settings, and across risk level. Likewise age, ethnicity, and other factors such as socioeconomic status, intellectual disability, or verbal IQ might be factors that would impact treatment responsivity.

This article reviews instruments for assessing moral or prosocial reasoning in the general youth probation population. Additionally, research on instruments for assessing the same factors for JwSO is reviewed which suggests that this area may be relevant for this population as well. All the instruments reviewed for JwSO, that is the Roberts 2, WUSCT, the PRO, and the PRO-S, are either public domain or relatively inexpensive. However, it should be noted that the PRO and the PRO-S are still in development. The tools can readily be administered, and in the author's experience, these measures have adequate face validity, and appear to in fact assess moral and prosocial reasoning. Also the results closely match what is observable in counseling with these youth. This is important in clinical work where the assessment information should reflect and elucidate the youth's functioning in counseling, residential, and everyday situations.

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THE FORUM NEWSLETTER

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Prosocial Treatment Methods for Juveniles Who Sexually Offended

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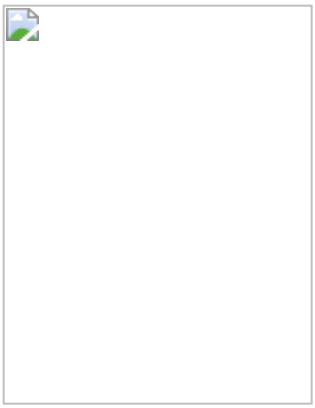

The treatment of juveniles who have sexually offended (JwSO) is challenging in several respects. While the harm done to the victims and prevention of future harm is always a concern, other issues need to be addressed. This includes a possible personal history of child abuse of the JwSO, other trauma history, family dysfunctions, substance abuse, school and peer problems, and comorbid psychiatric conditions. A recent ATSA Forum article (Ralph, 2017) recommends evaluating and considering another area of functioning for JwSO as well, prosocial or moral reasoning. That article suggested prosocial reasoning as a developmentally related criminogenic risk factor for these youth. This hypothesis relates to Bonner's (2012) finding that early adolescence is a high risk, transitory developmental period for committing illegal sexual behaviors, and there is no evidence that most JwSO have a lifelong, incurable sexual disorder or paraphilia. For example, a 14-year-old male may have adult sexual abilities and drive, but still have immature social judgment. Those 14-year-olds who may have deficits, relative to the average 14-year-old, regarding prosocial reasoning, may be at greater risk for general and sexual delinquency. Notably Bonner provides evidence that 14-year-olds have the highest incidence regarding sexual crimes of any age group, presumably related to this mismatch of abilities and judgment.

A relevant consideration is whether deficits in prosocial reasoning are treatable. Are there interventions that enhance prosocial reasoning, and have beneficial effects for youth on probation such as reducing recidivism or other positive outcomes? The current article will address this issue. There is a significant treatment literature regarding effective methods to promote prosocial reasoning in youth on probation, including Reasoning and Rehabilitation (R&R) and its adaptation for adolescents (R&R2;Ross & Hilborn, 2003), Moral Reconation Therapy (MRT;Little & Robinson, 1988), and Aggression Replacement Training (ART;Goldstein, Glick, & Gibbs, 1998). Also research by the author regarding prosocial treatments with JwSO is presented.

Reasoning & Rehabilitation (R&R) Program

The Reasoning & Rehabilitation (R&R) program is a cognitive-behavioral group based intervention developed in Canada, and is supported by positive outcome studies (Antonowicz,

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2005). A youth version for those under the supervision of social services or juvenile justice agencies was developed, the R&R2 Short Version for Youth (Ross & Hilborn, 2003). It is listed by the Washington State Institute for Public Policy (2016) as a beneficial practice for juveniles. The treatment model for the R&R2 uses a handbook, takes 12 sessions, and requires 18 contact hours. The authors of the R&R2 note:

Neuroscience has established that adolescence is a period during which youths are experiencing extraordinarily rapid brain development. Based on the neurocriminology model, the youth are engaged in prosocial simulation training and prosocial role-taking throughout the program in order to stimulate their development of prosocial neuronal connections - the foundation of a prosocial identity. (Ross & Hilborn, 2003, para. 7)

Field testing was conducted in Estonia, and an evaluation study was subsequently done in Scotland which found that youth who completed the R&R2 program had reduced antisocial attitudes and risk of offending, and improved problem-solving ability and behavior (Curran, 2006). Further research is needed to show the generalizability and robustness of these findings, and no research has yet been done using with model with JwSO.

Moral Reconation Therapy (MRT)

MRT is another group-based intervention, which uses a workbook as part of treatment (Little & Robinson, 1988). Training at accredited sites is required for use of the workbook. For youth the treatment program can be completed in approximately 26 sessions. Ferguson and Wormith (2013) reviewed 33 studies of MRT and reduction in recidivism was used as an outcome measure. They calculated an overall effect size for MRT of d= .32, but the juvenile effect size was d=.14. Two articles (Burnette, et al., 2003; Burnette, et al., 2004) showed positive changes with youth on probation using MRT, including increases in the level of moral reasoning. It is also listed by the Substance Abuse and Mental Health Services Administration as an evidence-based practice, and is included under juvenile interventions by the Washington State Institute for Public Policy in their meta-analytic review as a beneficial practice (2016). Although no studies with either MRT program have been used with JwSO,both MRT and R&R2 reduce recidivism with the general probation population, of which JwSO are a subset. Therefore, it is reasonable to hypothesize that these programs would also be effective with JwSO.

Aggression Replacement Training (ART)

Another approach which addresses moral or prosocial reasoning skills is ART (Goldstein, Glick, & Gibbs, 1998). It was developed primarily for juveniles on probation, using developmental psychology theories and research regarding child cognitive development, social learning, moral reasoning, and anger and emotional control. A central feature of this model is the promotion of moral or prosocial reasoning. The effectiveness of ART in reducing recidivism with youth on probation is also documented in a number of studies (e.g. Goldstein, Nensén, Daleflod, & Kalt, 2005). Amendola and Oliver (2010) in summarizing the literature note that ART is a "Model Program" for the United States Office of Juvenile Justice and Delinquency Prevention, and the United Kingdom Home Office.

The effectiveness of ART appears to be established for the general probation population. A question is whether ART is also effective and promotes positive outcomes for the subset of youth on probation with sexual offenses. The effectiveness of ART with JwSO was addressed in three related studies completed by the author. The same residential setting for JwSO was used in these studies. The first study was conducted in 2009 using a matched time series design with randomization (N=19). Outcomes were assessed using a psychological symptom inventory. Beneficial outcomes were found for reduced levels of psychological distress. This was the first randomized design done with any population with ART or with JwSO. However, it's important to note that long-term indicators such as recidivism or sexual acting out were not used as outcome measures.

A subsequent study in 2012, attempted to replicate these findings, but did not include a control group (Ralph, 2015a). However, additional psychological assessment techniques were used. The findings supported the hypothesis that ART contributed to therapeutic changes on psychological outcomes for youth in residential JwSO treatment. On the Child Behavior Checklist (Achenbach & Rescorla, 2001) completed by caregivers, five scales showed

improvement from pre- to post- treatment which were Social Problems, Attention Problems, Rule Breaking Behavior, Externalized Total, and Total. On the Symptom Checklist 90-R (Derogatis & Savitz, 2000) completed by the youth, the Anxiety scale showed significant changes. On the Youth Outcome Questionnaire (Burlingame, Wells, Cox, & Lambert, 2004) completed by caregivers, Critical Items also showed positive changes. Two measures of prosocial reasoning, the Washington University Sentence Completion Test (Hy & Loevinger, 1996), and the Prosocial Reasoning Outcomes (Ralph, 2016a) also showed positive changes. This 2012 study was the first to show changes in prosocial reasoning with ART. It is important to note that this study did not include a control group and had methodological limitations, including ruling out maturation, testing, or a placebo effect as rival hypotheses to explain changes in scores.

In both the 2009 and 2012 studies open-ended focus groups were conducted with ART participants where they reported positive outcomes consistent with the quantitative findings. Youth generally identified the following ART strategies as helpful in being able to inhibit impulsive or counterproductive responses to adverse situations, and to formulate more positive and prosocial action alternatives. Youth described that they could "check themselves before they wrecked themselves." Importantly they also described a "virtuous cycle" in contrast to their usual impulsive behavior. When youth began using prosocial coping strategies they began using them more because of the reinforcement from the positive results of these approaches.

A subsequent longitudinal study (Ralph, 2015b) was carried out which followed all youth admitted to the same residential program from 2006 to 2012 (n =129 male youth ages 12 – 17). Sexual acting out was one of several outcomes studied, and 126 cases had complete data regarding this variable. This variable was defined as any episode of significant sexual acting out, some of which may have been considered a violation of the law. A total of 20.6% of youth had at least one such episode. Also a total of 20.9% youth completed the ART program during that time period. The rate of sexual acting out for those who participated in ART was 7.4%, compared to 24.2% for those who did not. A one-tailed Fisher's Exact Test was used to compare the groups, which were significantly different, p=.042.

Although this series of research studies has various methodological issues, together they show promise that ART was related to general psychological outcomes and associated with reduction in sexual acting out. Further larger scale studies are needed to confirm these preliminary results.

Being a Pro

The author has developed a treatment workbook for promoting prosocial reasoning, titled *Being a Pro* (Ralph, 2016b). It was influenced by research regarding measures of prosocial reasoning (Ralph, 2017), and also research on ART noted above. The structure of the *Being a Pro* workbook was informed by current research regarding best practices for youth on probation, notably the studies reported above with JwSO youth with ART. These are summarized in a prior article (Ralph, 2012). Approaches which emphasize counseling and skill building are manualized, have fidelity checks, training and supervision of practitioners, are more effective for youth on probation. These factors are also emphasized by Lipsey (2009) in his review article of effective interventions for youth on probation. Goense, Assink, Stams, Boendermaker, and Hoeve (2016) conducted a meta-analysis of 17 studies of interventions for juveniles with antisocial behavior. They found a medium treatment effect when integrity was high ($d = 0.633$, $p < 0.001$), but no significant effect when integrity was low ($d = 0.143$, ns). Both fidelity and outcomes measures were incorporated into the Being a Pro model. An outcome study was conducted for Being a Pro with 39 male adolescents (average age 15.7 years) on probation, in either outpatient or residential treatment for sexual offending (Ralph, In press). Results were consistent with the hypothesis of positive changes in prosocial behavior and reasoning as a result of the prosocial intervention, the*Being a Pro* workbook. However, the design of a simple pre-post test did not rule out all rival hypotheses, and further research is necessary to validate the effectiveness of this approach.

Summary

There is reasonable evidence from research on ART and MRT that approaches which promote prosocial reasoning in youth on probation generally are effective in reducing recidivism. MRT

as noted above was also associated with improved psychological functioning in youth on probation. Also the ART studies with JwSO reported above indicate it is associated with positive psychological outcomes for these youth. The studies and methods reviewed had limitations, and additional research is warranted. Prosocial treatment methods and their theory are consistent with neurodevelopmental research regarding adolescence being a "critical period" in the development of prosocial behaviors. It is a period when these skills are developing, and also youth with deficits are at greater risk for delinquent outcomes. This seems consistent with the hypothesis that adolescence may be a critical period of brain plasticity to promote prosocial reasoning. In summary, the above research suggests that treatment of JwSO might include interventions to promote prosocial reasoning.

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2022

CASOMB's Guidelines for Treating and Supervising Youth Who Have Committed a Sexual Offense

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Executive Summary

Youth, ages 13-17, are significantly different from adults in virtually all aspects of life. For this reason, society restricts their right to drive a car, vote, purchase tobacco, alcohol or marijuana, consent to medical treatment, and serve in the military. Youth are in a developmental stage of life in which rapid changes and maturation processes are affected by many forces, including biological, familial, educational and social. Youth who have offended sexually have a low likelihood of committing a new sexual offense, with estimates as low as 2.75%. Common methods of supervision and treatment used with adult sexual offenders are, for the most part, inappropriate and potentially harmful with youth. The Board strongly recommends that youth who have offended sexually should have services specialized for their needs.[1]

Historically, the majority of services have been provided at the county level. With the closure of the Department of Juvenile Justice and the statewide realignment, all adjudicated youth will be retained at the county level for commitments and supervision. Resources and access to treatment services vary by county. Even when treatment is available, there is no statewide standard of care for youth who have offended sexually. Agencies, organizations and individuals who provide services to this population need standards based on what research shows to be the best approach to assure quality and consistency of services during intake, treatment, residential changes, treatment completion, and family reunification. ***In this document the Board has developed evidence-based standards and guidelines for a collaborative model of treatment and supervision of youth, supported by the principles of Risk-Need-Responsivity (RNR).*** These guidelines should apply for youth adjudicated for committing a sexual offense, and referred to attend sex offense specific treatment by the court. The intensity of services will be defined by individualized assessments of risk and treatment needs and managed by a case management team.

These standards will form the basis for specialized training for supervising officers and, if approved by legislation, specialized certification standards for treatment providers working with the youth population. The standards and potential certification requirements for providers who work with youth, must be distinct and separate from the Board's existing certification requirements for treatment professionals who work with adults. ***Given the necessary resources and jurisdiction CASOMB will monitor certified programs and treatment providers to assure delivery of services that are sensitive to the youth's needs and provided in culturally sensitive and trauma informed manner. Minor statutory changes will allow SARATSO to resume its role of selecting risk instruments for youth who have committed sexual offense.***

[1] California Sex Offender Management Board (CASOMB). (2019, January). *Juvenile Recommendations.* Retrieved: https://casomb.org/pdf/CASOMB_Juvenile_Recommendations_January_2019.pdf

Introduction

The purpose of the *Guidelines for Treating and Supervising Youth who have Committed a Sexual Offense* is to promote policies that achieve two primary goals:

1. Reduce both sexual and general criminal recidivism for youth.
2. Promote the prosocial and positive development of these youth and their future emotional, interpersonal, and occupational success.

Youth typically have low recidivism for sexual behaviors, one estimate indicates 2.75%. This means that only about 3 in 100 youth will commit a new sexual offense after being adjudicated. Nonsexual or general criminal recidivism is estimated to be 10 times higher than sexual recidivism.[2] This population also has a high prevalence of co-occurring psychiatric conditions including Attention Deficit Hyperactivity Disorder (ADHD), family dysfunction, trauma, mood disorders, learning disorders, and substance use problems.[3] Research indicates that treatment of such factors is important not only to promote the prosocial development of these youth but also may have an impact on decreased recidivism.[4] The low recidivism rate and development changes highlight the differences between youth and adults and the need for separate guidelines and practices for each population.

The following describes concepts important in the development of these youth guidelines that distinguish them from adult standards:

Neurodevelopment - Adolescence is a period of rapid physical, sexual, and brain development.[5] Areas which control decision-making are still developing. Immaturity in this area may contribute to harmful sexual or other problematic behaviors, while development in these areas during adolescence contributes to their desistance.[6] Treatment methods which promote psychosocial maturity are likely to reduce recidivism.

Collaborative model - The recommended model for providing services for Youth is the Collaborative Model. This model is appropriate for adolescents, and is distinct from the adult model Containment Model.

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[2] Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, and Law*, 22(4), 414–426. https://doi.org/10.1037/law0000094

[3] Epperson, D.L., & Ralston, C.A. (2015). Development and Validation of the Juvenile Sexual Offense Recidivism Risk Assessment Tool–II. *Sexual Abuse*, 27(6), 529–558. https://doi.org/10.1177/1079063213514452

[4] Lipsey, M., Howell, J., Kelly, M., Chapman, G. & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: a new perspective on evidence-based programs.* Center for Juvenile Justice Reform, Georgetown University.

[5] Jensen, F.E., & Nutt, A.E. (2015). *The teenage brain: A neuroscientist's survival guide to raising adolescents and young adults.* Harper Collins Publishers.

[6] Steinberg, L.D., Cauffman, E., & Monahan, K. (2015). *Psychosocial maturity and desistance from crime in a sample of serious juvenile offenders.* Office of Juvenile Justice and Delinquency Prevention.

Risk-Need-Responsivity (RNR) – The RNR model provides a framework for assessment that informs effective treatment and interventions. Juvenile instruments for assessing sexual recidivism and general criminal recidivism are generally as accurate as adult measure. Along with other information they can provide essential information for disposition and treatment planning.

RNR assessments provide information that facilitates risk reduction and prosocial development. Given that adolescents who have engaged in sexually abusive behavior are more likely to reoffend nonsexually, it is important that assessments address general risk. Assessments should focus on providing a broad, multidimensional assessment of the individual adolescent's treatment and support needs. This includes addressing issues that may impact the adolescent's response to interventions, such as language barriers or cognitive deficits. To be effective, assessments should focus on issues that impact healthy adolescent development and identify strengths and protective factors.[7]

Assessment - Given the high prevalence of co-occuring psychiatric conditions, nonsexual recidivism, and the need to identify types and risk levels for problematic sexual behaviors, comprehensive psychological evaluation using evidence-based methods and measures is recommended for these youth.[8] This should include measures of sexual and general criminal recidivism and also assessment of mental health needs and substance abuse issues.

Treatment - Treatment and disposition planning for youth should be evidence-based, and comprehensive. Treatments to reduce the risk of sexual recidivism should be complemented by treatments to reduce general recidivism, and treat co-occurring mental health factors. Treatment methods should incorporate evidence-based criteria which emphasize skill-building and problem-solving. Counseling methods should be matched to the youth's risk level and learning styles, and incorporate quality assurance and treatment outcome measures. Treatment approaches should also be "trauma-informed" and culturally sensitive.[9]

The following guidelines are provided to promote good quality RNR assessments that help inform decisions and interventions to prevent further offending, reduce future victimization, and promote community safety.

Recommendation Requirements for Treatment Provider Education, Experience, Training and Supervision:

Mental health professionals who provide therapeutic treatment services for youth who have offended sexually need to have specialized training, education, and experience that prepare them

[7] Association for the Treatment & Prevention of Sexual Abuse (ATSA). (2017). *ATSA Adolescent Practice Guidelines.* Retrieved: https://www.atsa.com/Members/Adolescent/ATSA_2017_Adolescent_Practice_Guidelines.pdf

[8] Land, R., Ralph, N,. Rasmussen, L., Miccio-Fonseca, L.C., & Blasingame, G. (2013) *Guidelines for the Assessment and Treatment of Sexually Abusive Juveniles.* California Coalition on Sexual Offending (CCOSO). Retrieved: https://ccoso.org/sites/default/files/Adol%20Guidelines.pdf

[9] Land et al., 2013

to work within this field. Assessment and treatment of youth who have committed a sexual offense, requires significant clinical skill and experience. A competent therapist will have specialized knowledge and training, and the skills to utilize techniques that are based on empirical evidence. Maintaining and demonstrating evidence of one's scope of practice and scope of competence in working with youth who have offended sexually is the legal and ethical responsibility of each licensed psychotherapist in California treating these individuals.

1. Eligibility to Practice

Individuals who provide treatment services in California may work independently and provide supervision to those who do not meet the criteria to work independently. An independent provider must be licensed to provide mental health services in the state of California, per the Board of Behavior Science, Board of Psychology, or Medical Board.

2. Education

The provider's education should be consistent with the requirements to become licensed within the state they practice.

3. Experience

In order to provide services independently, under CASOMB's Guidelines, a provider must have sufficient experience in the treatment and evaluation of youth who have sexually offended. The provider must have completed 750 hours of direct experience providing sex offender specific individual, group or family therapy, , or evaluation within the last 5 years or 2000 hours over the course of their lifetime. No more than 20% of the experience can be accrued while providing services to youth for nonsexual offenses.

4. Training/Continuing Education

In order to maintain the most current and up to date evidenced based practices, the provider must complete 24 hours of training or continuing education every two years. The training should focus on topics related to the treatment, evaluation, development, research, and supervision of youth who have committed a sexual offense.

5. Clinical Supervision

If providing supervision, to unlicensed providers or those new to the field, the Independent supervisor must ensure that the unlicensed provider meets the qualifications for providing mental health services in the state of California (or the state in which they practice). Supervision should be provided in such a way that it supports the growth and development of the unlicensed provider or the licensed provider who is new to the field, and should meet all licensing Board requirements for supervision. A minimum of one hour of face-to-face supervision should be provided to those who do not meet the requirements for Independent status. Due to the nature of forensic work it is important that providers incorporate self-care and training for the prevention and treatment of vicarious trauma, both for themselves and for those they supervise.

Treatment Provider Agency Requirements

The agency guidelines are organized into several key areas:

1. Implementation of the Collaborative Model
2. Placement of Youth
3. Use of Polygraph
4. Informed Consent Paperwork
5. Assessment
6. Treatment Plan
7. Treatment Modalities
8. Treatment Completion
9. Other Documentation

1. Implementation of the Collaborative Model

The Collaborative Model of youth supervision "is used in several ways and mirrors characteristics of many of the systems with which the youth interacts. It is intended to create an optimal relationship between the youth, his or her family, probation, and treatment providers."[10] The Collaborative Model emphasizes a team approach and promotes the prosocial behavior of the youth while also protecting public safety. This method goes beyond managing potential inappropriate behavior in the community.[11] Supplementing the Collaborative Model with the RNR principles helps clinicians and supervising officers enhance outcomes by delivering individualized therapeutic intervention and supervision.[12]

The Collaborative Model relies on open and consistent communication between the probation officer and treatment provider Communication should occur at a minimum once a month, and regularly scheduled meetings are encouraged. Regular meetings allow the treatment and supervision team to share information in a comprehensive, coordinated, collaborative approach to identify, manage, support and supervise youth adjudicated for sexual offending behaviors.

Additional meetings and communication should take place with the Case Management Team (CMT). The CMT should include the probation officer, the treatment provider, the youth and other key stakeholders involved in the youth's life, such as the youth's family or guardian, mentor, social worker, psychiatrist, school representatives or members of the Child and Family Team (CFT).[13] The additional key stakeholders should attend as needed. The goal of the CMT communication is to collaboratively work with the youth and individual's in their life to promote a comprehensive holistic plan for the youth's success. Promoting prosocial values through the CMT will increase community safety.

[10] Land, R. et al., 2013, p. 7.
[11] Land et al., 2013
[12] Land et al., 2013; CASOMB Juvenile Recommendations, 2019
[13] Welfare & Instititions Code, §§ 727(a)(4)(A), 727.1(a), 727.2, 16501(a)(4).

A. Risk Level Assessment

Empirical risk assessment of youth in the community is an optimum way to inform the Case Management Teams of the risk level of the person they are treating or supervising.[14] California law required the use of risk assessment instruments only for juveniles recommended for placement or after placement at the highest level of state supervision at DJJ. The State Authorized Risk Assessment Tools for Sex Offender (SARATSO) committee mandated the use of the JSORRAT-II be scored for this purpose. Starting on July 1, 2021, changes made as a result of SB823, voided this requirement. In line with best practices, it is recommended that youth, who are eligible for scoring, be assessed by probation post-adjudication and pre-disposition with a risk instrument, such as the previously SARATSO selected JSORRAT-II or other risk instrument for youth, which is valid an reliable. A valid and reliable instrument is one that research has shown, not just once but several times, by the test developers and other researchers that it consistently measures what it is intended to measure. A process and structure is in place for the SARATSO Review Committee to select relevant risk instrument and to train scorers statewide. SARATSO should be given the statutory purview to implement this process for youth adjudicated of a sexual offense.

B. Supervision Decisions Guided by Evidence-Based Standards

Frequency and type of treatment, supervision methods, Internet usage, contact with families, use of GPS (global positioning systems), and limited use of polygraph exams are all examples of the types of decisions that should be made by the collaborative team. Methods of supervision must be appropriate and consistent with public safety and accountability of the youth. This includes referral for mental health needs, substance abuse issues, or educational needs. Decisions regarding supervision methods should be based on results of a comprehensive assessment of the youth and the judgment of the CMT.

C. Specialized Caseloads and Training

When feasible, probation officers should supervise this population on specialized caseloads for youth who have committed sexual offenses. Probation officers with this caseload should receive specialized training to enhance their ability to effectively supervise youth, in order to protect the community, reduce recidivism, and assist with prosocial development. Supervising officers should attend training about juvenile brain development as it relates to effective supervision practices for youth. Supervising officers must also learn effective methods for communicating with the treatment provider agencies, and caregivers, and how to use the Collaborative Model effectively. This includes understanding how to interpret risk assessment scores and clinical recommendations. Supervising officers handling these caseloads should receive specialized training during their first year of assignment to this type of caseload.

[14] CASOMB Juvenile Recommendations, 2019

2. Placement of Youth

A. Out of Home Placements

Out-of-home placement is pursuant to the Welfare and Institutions Code,[15] which states that all youth in placement are to have a child-centered service plan including parental participation on the Child and Family Team.

Youth who have offended sexually are often removed from their family homes. Sometimes this is because their victim(s) live in the family home. Other times it is because the youth is beyond the parents' capacity to control, there is no viable family placement, or the youth's offense(s) are particularly egregious. Some youth are simply thought to be too high risk for community placement. Research indicates, even for youth with high levels of risk, there is no incremental benefit for out of home placement relative to community placement. Best practices indicate that the least restrictive environment be identified and with family wherever possible.

Congregate care is an important component to the continuum of care for this population. It is an appropriate option for youth with treatment needs that cannot be met through outpatient treatment. It is a valuable intermediary for youth who need the strict supervision that residential treatment can provide, while providing them with a chance to address their sexual problems and offending behaviors without the potential consequences that come with registration requirements. With the requirements on Short Term Residential Treatment Programs (STRTPs), there are expectations that residential programs include trauma-informed care and utilize certain assessments. The Board believes that youth who have offended sexually, and who are placed in STRTPs, should receive additional support and services specific to this population, that would translate needs and treatment outcomes across placement settings.

The Board believes that regardless of where the youth lives, he or she should receive the best possible support and services, and that family reunification should be the goal in all feasible cases consistent with community safety and the youth's best interests. The Board believes that statewide, systemically and similarly organized services should be accessible across the continuum of care for youth who have offended sexually. Youth who are placed in the community may at a later time need a higher or lower level of placement. Likewise, youth who are placed in an institutional setting will eventually be released to a community placement or their families. With youth-specific certified treatment programs and providers adhering to these Board requirements, regardless of placement setting, youth will be able to receive similar care with evidence-based methods and methodologies.[16]

[15] Welf. & Inst. Code, §§ 727(a)(4)(A), 727.1(a), 727.2, 16501(a)(4).
[16] CASOMB Juvenile Recommendations, 2019

Such consistency does not exist at this time. If a youth is moved from one placement to another, he or she is likely to have to start a new treatment program. Prior treatment efforts are often set aside as each independent treatment program or provider has their own strategies and methods. Some individuals transferring from one program to another have been required to rewrite prior documents solely to include the new program's terminology. Other individuals are not credited for treatment efforts done elsewhere if a copy of those materials is not available to the new program.

For these reasons, the Board believes it is in the interest of public safety and youth offender rehabilitation that these Board recommendations apply to all treatment service providers regardless of the youth's residence or placement setting.

B. Juvenile Court Transfer

Under current law, a prosecutor may make a motion to transfer a minor who is 16 or 17 years of age from juvenile court to a court of criminal jurisdiction in any case in which the minor is alleged to have committed a felony. Most youth would not be considered routinely for such a transfer, and this is usually expected to apply only in extraordinary situations. The Youth Guidelines highlight how different youth are from adults. This corresponds with a lower recidivism rate for youth, estimated at approximately 2.75%.

The Centers for Disease Control has concluded: "[T]ransfer policies have generally resulted in increased arrest for subsequent crimes, including violent crime, among youth who were transferred compared with those trained in the juvenile justice system. To the extent that transfer policies are implemented to reduce violent or other criminal behavior, available evidence indicates that they do more harm than good."[17] Over the past 10 years, in California, the number of transfers from youth to adult court has significantly decreased. Youth will benefit from remaining in the juvenile justice system and receiving developmentally appropriate services.

For a detailed description of the juvenile court transfer process please see Appendix C.

3. Use of the Polygraph

Polygraph exams in supervising youth in this population should not be the norm, should be rarely used only when justified on a case-by-case basis. Best practices indicate that its use should be limited to youth age 16 or 17.

- Any use of polygraph in California with juveniles should be governed by youth-centered standards developed by the Board for both treatment and polygraph which are developmentally suitable and empirically based. The decision whether to use polygraph with youth, and what

[17] Hahn, R., et al,. (2007). *Effects on Violence of Laws and Policies Facilitating the Transfer of Youth from the Juvenile to the Adult Justice System*. Center for Disease Control and Prevention, Morbidity and Mortality Weekly report, 1-11, p. 9.

type of exam is indicated and in what circumstances, should be guided by standards to be promulgated by the Board.

- Polygraphs should not be used with any youth under the age of 16.
- In rare cases, a polygraph exam may be conducted with a youth age 16 or 17, if recommended by the youth's CMT.[18] Polygraph is only recommended in situations in which it is necessary to maintaincommunity safety, due to the concern of an imminent sexual offense. The CMT should consider factors such as age, trauma background cognitive development, treatment issues (e.g., denial), and potential harm to the youth prior to determining if use of polygraph would be appropriate in a particular case.
- Polygraph examinations results cannot be used for determining whether family reunification, or incarceration, is appropriate.
- Any use of polygraph with youth requires appropriate use immunity, such as offered in Oregon.[19] California law provides similar immunity protection, as explained in *People v. Garcia* (2017) 2 Cal.5th 792. California law conferring legal protection from disclosures should be explained in the standards, and the parameters of the polygraph examination should be defined (pre-polygraph interview, polygraph exam, post-polygraph interview).
- If a polygraph examination is required, then appropriate waivers of confidentiality, must be provided to the youth and their parent/guardian.
- Polygraph examiners working with youth require a specified amount of training hours in youth cognitive development as well as experience conducting polygraph exams with youth.[20]

Polygraph exams should be coordinated by the CMT, with input from the treatment provider and probation officer. Polygraph exam reports must be provided to the treatment provider and polygraph examiner within 5 days of the exam. Requiring a second polygraph due to inconclusive, or significant responses is not recommended.

4. Informed Consent, Waiver of Confidentiality, Release of Information, Treatment Contract

The provider agency shall have forms for obtaining Informed Consent to Treatment, Waiver of Confidentiality, Authorization for Release of Information, and a Treatment Contract, that should be reviewed with both the youth and the youth's parent/guardian or caregiver. All forms should be at a 4th grade reading level, and the treatment provider should ensure all forms are easy to understand for the youth. For youth or families with reading challenges, oral review of the content of these documents is recommended. For non-English speakers, a translator should be used to provide written or oral explanation in the appropriate language. Attention needs to be given so that the match between the translator's language skills and those of the youth and family is appropriate given dialect differences between regions.

[18] ATSA, 2017

[19] Hindman, J. & Peters, J. (2001). Polygraph Testing Leads to Better Understanding Adult and Juvenile Offenders. *Federal Probation*, 65(3), 8-15.

[20] CASOMB Juvenile Recommendations, 2019

A. Informed Consent/Treatment Contract

Youth and their parent/guardian should understand the screening, assessment and treatment processes prior to the onset of services. Youth participating in treatment and/or screening and their legal guardian (if not an emancipated minor) are required to give informed consent for assessment and treatment. Provider agencies or providers should use language that each client can comprehend. Youth who refuse treatment must be advised that refusal to give consent can result in not being accepted in the treatment program. The provider agency must ensure that the youth has the capacity to understand and give informed consent.

The roles and responsibilities of the provider agency and what is expected of the youth and their parent/guardian should be included. Such agreements can be particularly useful in establishing the youth's responsibility, accountability, and ownership with respect to his or her engagement in treatment. They document in writing that the youth and parent/guardian have been informed of the conditions and requirements of the treatment program as well as the consequences of violating these conditions. Treatment consequences may include written warnings, remediation plans, suspension, or discharge from treatment. The youth and parent/guardian should be made aware that their status in treatment may impact compliance with the conditions of probation.

The following components should be included in the informed consent form:

1. A description of the assessment and treatment processes
2. Description the type, frequency, and requirements of the treatment program, and outline how the duration of treatment will be determined;
3. A statement regarding the possible benefits and risks of treatment, and possible adverse effects of treatment
4. Consequences of refusing to participate in treatment
5. Alternative forms of treatment, for example whether or not to take a medication
6. An explanation of the limits of confidentiality including the possible legal impact of disclosures
7. Training, education, and experience of the treatment provider
8. Name and contact information for the clinical supervisor of unlicensed providers
9. An explanation of the nature of, limitations and boundaries of the therapeutic relationship
10. A statement allowing for open, two-way communication between the professional staff members within the provider agency to facilitate communication related to supervision, consultation, case conferencing, back-up, and other interagency communications
11. Information about client fees for assessment, treatment, polygraph examinations and other costs. The fee schedule should comply with Federal No Surprises Act.
12. A statement explaining client rights and responsibilities, including maintaining the privacy and confidentiality of other persons who are in the treatment program
13. A description of the agency's internal complaint process and the CASOMB complaint process
14. For internal research the provider agency must state its policy on the use of file information for research and on the solicitation of client participation in research projects, whether within the agency or by outside investigators.

15. Define the **role and responsibilities of the youth and parent/guardian** (as applicable) with respect to, at a minimum, the following areas:
    a. Describe and clarify program rules and behavioral expectations;
    b. Describe compliance with attendance policies and procedures for handling cancellations and tardiness
    c. Describe expected participation in assessments, treatment sessions and treatment homework
    d. Describe provider's expectation that the client notify the treatment provider of any changes or events in the life of the client, the members of the client's family, or support system;
    e. The expectation of the parent/guardian to support the youth and/or participate in some level of treatment or classes.
    f. Describe any other provider agency rules and requirements to which clients are expected to adhere.

NOTE: The above list is not intended to be a legal guide or a comprehensive, authoritative review of all the elements required for informed consent.

B. Waiver of Confidentiality

Youth and their parent/guardian must clearly understand that they will be expected to give their written permission (*Waiver of Confidentiality* or *Authorization for Release of Information*) for the provider agency to share information about them with supervising officer and members of the CMT. A provider shall explain to youth that information disclosed in a mental health treatment context is confidential with certain exceptions. The other limits of confidentiality, such as child abuse reporting, elder abuse reporting, *Tarasoff* warnings, and suicidality should be enumarated.

The waiver must explain that the following entities are required to communicate openly with each other regarding risk related information: supervising agency, treatment provider agency, and other key members of the CMT. A separate release of information form must be generated and signed for the polygraph examiner if a polygraph examination is conducted.

The provider agency's waiver of confidentiality form must meet professional standards of practice and must be written so that it can be understood by the individuals who are required to sign it. In accord with the Health Insurance Portability and Accountability Act (HIPAA) regulations, the provider agency must provide a statement of its privacy practices which addresses the handling of confidential client information and documents.

C. Authorization for Release of Information

Providers must obtain a signed authorization to exchange information with other entities.

1. CASOMB conducts compliance reviews of providers and provider agencies. Authorization to Release Information must include CASOMB or the CASOMB designee.

2. Communication with adjunct participants (youth mentors, school representatives, etc.) in the CMT team requires a release of information.
3. If the offender has additional therapists or treatment providers external to the certified provider agency, a separate release shall be arranged for each of the professionals involved.
4. When working toward reconciliation, a release of information for the victim's therapist, shall be signed.
5. External consultants or external clinical supervisors involved with the treatment program shall also be listed on the release of information forms before a case is discussed with them.

5. Assessment

Comprehensive assessments are the foundation for identifying risk levels, treatment targets and needs, and responsivity related issues. Relevant factors that are to be addressed as part of disposition and treatment planning need to be reliably assessed using evidence-based best practices. A comprehensive evaluation should include clinical interviews with the youth and their parent/guardian, a thorough document review, collateral contacts when appropriate, and psychological tools. A comprehensive psychological assessment should be completed, by a qualified licensed mental health provider, for the youth post-adjudication and pre-disposition. If a comprehensive evaluation is unable to be completed pre-disposition then it should be completed prior to or concurrently with the commencement of therapy, and should include the following elements:

- Assessment of sexual recidivism risk using a validated risk instrument for sexual re-offense
- Assessment of general criminal recidivism using a validated instrument
- Prior delinquent behavior
- Comprehensive assessment of co-occuring psychiatric factors, including mental health issues, substance use problems, adverse childhood experiences, trauma history, and family factors.
- Given the high rate of learning and cognitive disorders for this population, assessment of cognitive and academic functioning, is necessary. Formal cognitive and academic testing which has been recently completed, by schools or associated organizations can be integrated into assessment findings.
- Social and familial relationship history
- Pertinent medical history
- Factors which impact engagement, motivation and amenability to treatment

Areas to be assessed include static factors which describe historical aspects of the youth likely not to change and dynamic factors related to the youth's current situation, experiences, environment, and beliefs, which may be changeable.[21] Research regarding instruments is ongoing and the

[21] Worling, J. R. (2004). The estimate of risk of adolescent sexual offense recidivism (ERASOR): Preliminary Psychometric Data. *Sexual Abuse*, 16(3), 235–254. https://doi.org/10.1177/107906320401600305

selection of instruments should be based on current research and best practices. The use of such measures provides one source of data regarding how treatment planning should be structured to account for the risk of recidivism.. Probation departments, state agencies, and treatment providers may make selections among available instruments.

General Criminal Recidivism Measures: Parallel to the use of sexual recidivism measures, it is essential to assess the youth's risk of general criminal recidivism or nonsexual crimes. Nonsexual crimes for youth occur at about 10 times the rate of sexual crimes and have victims too. Scientific criteria for use of such measures is the same as those described for sexual recidivism measures. A number of instruments are available in this area that have acceptable research findings. These instruments provide assessment of areas of focus for disposition and treatment planning.

Mental Health Needs: ADHD, anxiety disorders, mood disorders, PTSD, familial challenges, and substance use, among other factors, should be assessed. These conditions have a high prevalence in this population.[22] When such factors are adequately assessed it is more likely that the dual goals, reducing recidivism and promoting the prosocial functioning of youth will be achieved. These factors are assessed by mental health methods which include clinical interview, review of history, and use of appropriate psychological tests.

Cognitive, academic, and neuropsychological factors: Youth have a high incidence of learning problems. One study notes for youth in detention for general probation issues, 35.6 percent were learning disabled, and 12.6 percent had an intellectual disability.[23] For some youth with a history of neuropsychological disorders, specific neuropsychological assessment may be warranted. Referral issues might include a history of head injury, brain cancer and/or chemotherapy, prenatal substance abuse exposure, autistic spectrum disorders, or genetic or perinatal conditions (e.g., fetal alcohol syndrome or microcephaly).

Reassessment: Dynamic factors which may impact recidivism and prosocial development should be reassessed to determine the need for additional treatment, some of which may extend beyond the probation period

6. Treatment Plan

The provider agency shall develop and make consistent use of a written treatment plan for each youth that articulates treatment goals agreed upon by the CMT. The treatment plan should be reviewed with the youth and may include the case management team. The initial review, should occur within 60 days, and shall not exceed 120 days. Treatment Plan should be periodically reviewed and updated. Updated treatment plans should be shared with the CMT. Quarterly reviews is a standard practice.

[22] Epperson, D.L., & Ralston, C.A. 2015

[23] Casey, P., & Keilitz, I. (1990). *Estimating the Prevalence of Learning Disabled and Mentally Retarded Juvenile Offenders: A Meta-analysis* (Report No. 124182). U.S. Department of Justice Office of Justice Programs. https://www.ojp.gov/ncjrs/virtual-library/abstracts/estimating-prevalence-learning-disabled-and-mentally-retarded

The treatment plan articulates a set of achievable goals and evidence based interventions that provide a way to measure and record progress or the lack of progress toward those goals. The treatment plan should allow a way for the program to assess the level of compliance and effort demonstrated by the participant.

Treatment planning and delivery follow RNR principles. A written treatment plan shall be developed for each youth that starts with a comprehensive assessment. This includes identified factors which contribute to that individual's risk to reoffend sexually and non-sexually.

The treatment plan is a living document which is updated at various points during the course of treatment. The treatment plan is designed to reflect and document progress and to be a significant resource for determining when treatment has been completed.

Youth should collaborate in the development of the treatment plan and identification of goals. To show their agreement with the treatment plan, the youth should sign the initial plan and any subsequent updates, and shall be provided a copy. Since information in the treatment plan can be useful in guiding supervision strategies, providers shall make a copy of the treatment plan available to the supervising officer, when created and updated.

The program shall utilize an evidence-based approach to creating the treatment plan so that it is supported by the professional literature to reduce recidivism and promote prosocial functioning and development of the youth. The treatment plan shall be designed to assist and guide youth to address any or all of the following:

1. Develop motivation for change and deeper engagement in the treatment process.
2. Develop increased understanding of the nature and role of thoughts, feelings, and behaviors in the development and maintenance of adaptive and maladaptive behaviors.
3. Increase knowledge of personal responsibility.
4. Develop and practice self-management skills.
5. Increase knowledge of healthy vs unhealthy relationships and begin to make personal decisions regarding relationships.
6. Explore interpersonal characteristics and promote the development of new interpersonal characteristics.
7. Explore empathy and develop increased perspective-taking.
8. Examine healthy and unhealthy behaviors and the effects of each on others.
9. Understand the effects of criminal behaviors on others.
10. Learn to challenge irrational thoughts
11. Learn how to thoughtfully weigh decisions before making them.
12. Learn and apply independent living skills.
13. Develop and implement practices to promote and preserve a healthy lifestyle
14. Develop a plan for self-monitoring and self-management to meet needs in a healthy way.
15. Appreciate the impact of sexual offending upon victims, their families, and the community.
16. Develop an individualized safety plan.

17. Manage and respond to emotions and impulses in positive, prosocial ways.
18. Develop healthy interpersonal skills, including communication, perspective-taking, healthy sexuality, and intimacy.
19. Develop prosocial image and activities.
20. When appropriate, counseling/education with parent(s)/guardian(s) to promote positive treatment goals for the youth and develop relevant skills.
21. Establish, maintain or expand positive support systems.
22. Identify and address any additional criminogenic need areas.

7. Treatment Modalities

Provider Agencies are expected to determine the modality of treatment based on the responsivity issues of the youth. The youth's assessment should on a case-by-case basis guide if individual treatment or group treatment will provide the best therapeutic environment for growth. The literature supports the use of individual therapy without a group component or group therapy in conjunction with individual therapy . Factors that impact group placement, include mental health issues, level of cognitive functioning, sexual or gender identity issues, or other individual factors. Not all youth will benefit from participation in group therapy. ***If*** the juvenile is clinically appropriate for group treatment, and groups are utilized, the following are recommended:

a) Groups shall have no more than eight participants assigned per group.
b) A group made up of between five and eight clients shall not be less than ninety minutes in length per group session
c) Groups should be clustered by age, separating younger and older youth.
d) Commingling male and female clients in the same group is not supported

Additional modalities, such as family therapy or skills based training should be determined on a case-by-case basis.

All treatment should have:

1. Sensitivity to cultural diversity – Services need to be provided in a language appropriate for the youth and their family/guardian. Translation services should be used as a last resort.
2. Procedure for modifications to modalities when working with individuals who have unique or special needs such as cognitive limitations, mental health issues, language or other barriers that may impede effective treatment
3. Consideration where applicable for victim reunification or contact with victims. The guiding criteria for this would be "best interests of the victim" as described elsewhere in this document. Reunification is not considered the default choice.

CASOMB recommends individuals identified as above-average or well-above average risk should receive a higher dosage of treatment than those at lower risk levels. The Collaborative Team shall determine frequency and duration of services. Justification for frequency and duration shall be clarified in the treatment plan based on individual characteristics.
CASOMB expects programs to utilize evidence based methods and modalities based on the client's needs and responsivity issues. The goal of such methods is to increase the youth's level of

psychosocial maturity and problem-solving, to reduce the risk of future harmful behaviors and to promote a positive and prosocial lifestyle. It is hypothesized that these different approaches likely all promote these outcomes. These include but are not limited to:

- Cognitive behavioral therapy (CBT)
- Strength-based interventions
- Pro-social life goals
- Trauma informed care
- Mindfulness meditation
- Dialectic behavior therapy (DBT)
- Brain based change and bio-feedback
- Eye movement desensitization and reprocessing (EMDR)
- Motivational Interviewing (MI)
- Behavioral conditioning
- Manualized treatment protocols emphasizing skill-building, problem-solving, and counseling methods, and includes methods to address the reduction of sexual and nonsexual recidivism.

A. Special Populations and Treatment Considerations

a. Females

It has been estimated that 5-8% of youth who sexually offend are females. Studies indicate that compared to males, female youth who offended sexually were likely to be younger and less likely to commit acts of rape. Female youth were more likely to be victims of sexual abuse and experienced more types of abuse. There may be higher levels of co-occuring psychiatric factors such as depression, anxiety, and suicidal behaviors. Also, the characteristics of female and males are different not only biologically, regarding sexual development and drive, but in terms of gender roles and socialization. Treatment approaches need to be adapted to these factors. Assessment of risk for sexual recidivism in females is challenging and a limited number of instruments are available.[24]

b. Mental Health Issues

Literature has identified that youth who have committed a sexual offense have a high prevalence of co-occurring psychiatric and learning deficits or disabilities.. Many of these factors are treatable and can be improved. Identification of these factors as part of the assessment and facilitating evidence-based interventions to remediate these is an important goal. There is a significant literature supporting the effectiveness of interventions to remediate these factors. If not provided

[24] Righthand, S., Welch, C. (2001). *Juveniles Who Have Sexually Offended: A Review of the Professional Literature.* (Report No. 184739). Office of Juvenile Justice and Delinquency Prevention. https://www.ojp.gov/pdffiles1/ojjdp/184739.pdf

adequate assessment and treatment, these factors may contribute to recidivism. Relevant research is described below.

The Commission on Youth, Commonwealth of Virginia (2011), reports up to 80% have a diagnosable psychiatric disorder. Thirty to 60% exhibit learning disabilities and academic dysfunction.

ATSA Guidelines (2017) notes research has identified a higher incidence of mental health related disorders in juveniles with harmful sexual behaviors. The ATSA guidelines discuss a large meta-analysis with prevalence rates as follows:

- 69% at least one mental disorder
- 51% Conduct Disorder
- 44% at least two mental disorders
- 30% at least one substance use disorder
- 18% Anxiety Disorder
- 14% ADHD
- 9% Affective Disorder
- 8% PTSD

Epperson (2006) reported 25% of these youth had a diagnosed self-regulation disorder including ADHD, Impulse Control Disorder, Conduct Disorder, or Oppositional Defiant Disorder. Twenty percent (20%) had a diagnosis of an affective disorder including depression, anxiety, or bipolar disorder. Twenty-nine percent (29%) had a history of special education status. In Epperson's study each of these factors approximately tripled the risk of sexual recidivism.

c. Intellectual Disability

According to the DSM 5, about 1% of all youth in the general population have a diagnosis of intellectual disability and 2% have a diagnosis of autistic spectrum disorder. The number of boys with autistic spectrum disorder is four times greater than girls in the general population.[25] Youth with these characteristics likely have different victim and offense characteristics, and factors that motivated sexual offenses. Learning styles for these populations are distinct from the general population and it is important to identify areas of relative strength and treatment methods. They may have distinct patterns of judgment and insight that both contributed to offending and should be targeted in treatment. Youth with intellectual disabilities may have greater vulnerability to mood problems and suicidal ideation. Special adaptations regarding assessment and treatment should be implemented with these youth.[26]

[25] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

[26] National Institute of Mental Health. (2022). Autisim Spectrum Disorder (ASD). Retrieved October 20, 2022, from https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#:~:text=Across%20the%20CDC%20surveillance%20sites,all%20racial%20and%20ethnic%20groups.

d. Emerging Adults, age 18-25

Emerging adulthood is a developmental stage that occurs between the ages of eighteen and twenty-five. Emerging adulthood is often characterized by instability and as an age of exploration, during which drug, alcohol and sexuality experimentation are common. Emerging adulthood provides an increased level of freedom and less social controls than youth between the ages of 13 and 17. The risks and needs of this age group are different from adolescents, yet, this group is also different than adults and is often described as the emerging adulthood gap. This influences behavior and often the feeling of being "in between".[27]

California allows for youth to be sentenced under the juvenile system until the age of 25. This poses a unique challenge in assessing risk and providing appropriate treatment to a population that committed an offense under the age of 18, but is now between the ages of 18 and 25. It is important to acknowledge the differences in the risks and needs of this age group while still recognizing that the offense occurred under the age of 18.

Successful treatment and outcomes are best when approaches are tailored based on individual factors, risk level and interventions that target changeable risk factors. Therefore special guidance is required in recognition that emerging adults falls between the researched populations of juveniles who committed offenses under the age of 18 and individuals who committed offenses as an adults. To achieve positive outcomes with emerging adults, it is important to determine where the youth falls on the developmental continuum, their associated treatment needs and recidivism risk.

There is an identified gap for this population with risk assessment tools as most are validated on either a juvenile sample, with some going up to age 19 or an adult sample where the offense was committed at 17 or above depending upon the tool. Questions remain about which assessment strategies are most reliable given the uncertainties about reliability and validity with this specific population.

The compendium of dynamic risk factors for adults and youth with sexually abusive behavior, framed within the context of developmental goals, challenges, and characteristics of the emerging adulthood stage are grounding points for intervening with this population. This framework also allows for an acknowledgement that the difficulties faced by this population are similar in many ways to the challenges and difficulties faced by their non-justice involved peers as part of the normative life course.[28]

[27] Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. American Psychologist, 55(5), 469–480. https://doi.org/10.1037/0003-066X.55.5.469
[28] Arnett, J. J. (2000).

e. Family Therapy and Parenting

Research has identified that family functioning and parenting have been identified as an important factor in youth offense behavior and treatment success.[29] Epperson (2006) reported 26% of juveniles who sexually offended had severe difficulty relating to parents and 26% relating to siblings. These factors approximately tripled sexual recidivism. Family and parenting risk factors include: low parental monitoring, high conflict, and low affection contribute to increased recidivism. Treatment approaches that address improved family functioning have better outcomes and is associated with decreased sexual and general criminal recidivism.[30]

The focus for some families may be improved parentings skills, while others may need family therapy to identify and address problematic family dynamics. The motivation and availability of families differ for treatment involvement. Developing systematic strategies to include families in treatment is important.[31]

f. Reconciliation

For some youth, the victim of the offense was a younger sibling or child in the household. One study for example found that 43% of young adults who were sexually abused as children were victims of sibling sexual abuse.[32] There may be similar situations such as the offense occurring in a separate household with a half-sibling or other relative. As a result, the siblings are usually separated, with the offending sibling placed outside the residence where the victim resides. This is to ensure both the physical safety of the victim and to create a safe environment. There may be circumstances where reintegration of the offending youth into the family residence is appropriate. The primary consideration is what are the interests and needs of the victim. Typically such a process takes place after considerable time and treatment. It usually requires not only the offending youth, but the victim separately to be in counseling and therapy. It requires approval of the courts, probation officer, and if present, the child welfare worker. There should be a determination and recommendation from the victim's therapist, in consultation with the parent of the victim, that such a reunification is desirable and in the best interests of the victim. The wishes of the youth or parent, and practical or financial considerations should not be the primary concern. This process often involves the victim and family making sufficient progress in treatment where such a step is practically and emotionally desirable. Likewise, it requires that the offending youth's therapist believes that the youth does not pose a significant risk to the victim, others, or generally, and that

[29] Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology*, 77(1), 26–37. https://doi.org/10.1037/a0013035

[30] Borduin, Schaeffer, & Heiblum, 2009

[31] Bonner, B.L. *Take Action Support for Families of Adolescents with Illegal Sexual Behavior*. Safer Society Press. https://safersocietypress.org/store/taking-action-adolescents-download/

[32] Queensland Government. (2022). *Child Safety Practice Manual When a child is sexually abused by another child or a sibling*. https://cspm.csyw.qld.gov.au/practice-kits/child-sexual-abuse/working-with-children-who-display-sexually-reactiv/seeing-and-understanding/when-a-child-is-sexually-abused-by-another-child-o#:~:text=A%20study%20by%20the%20NSPCC,abuse%20(Stathopoulos%2C%202012)

they can manage the reunification. This involves the use of concrete steps in family meetings and agreement about arrangements that occur over time as part of a deliberate plan. Published guidelines and protocols can aid this process.[33]

8. Treatment Content and Completion

"Successful treatment completion" is defined as having "demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan" at the time of release from active treatment.[34]

Treatment should address several issues, including factors affecting both sexual and nonsexual recidivism, and co-occurring psychiatric factors. Separately additional recommendations can be made to school districts regarding appropriate educational accommodations through the development or modification of an Individualized Education Plan (IEP) or 504 plan. Treatment approaches should be trauma-informed and culturally sensitive. Manualized treatment protocols emphasizing skill-building, problem-solving, counseling methods, and includes methods to address the reduction of sexual and nonsexual recidivism can be helpful. Referral of the youth for treatment of mental health factors may be necessary.

Treatment for sexual recidivism:

The same criteria for identifying treatment methods for general recidivism are relevant for programs for youth who offended sexually. These treatment programs often include content related to sexual behaviors, understanding of causal factors relating to sexual offenses, and teaching skills and strategies to prevent future problems. Regarding evidence-based programs that meet these criteria, only one has been identified: Multisystemic Therapy (MST). MST has an extensive research showing positive outcomes.[35] Other programs have also been designed that show promising results. Kettry & Lipsey (2018) in their study of 9 programs with adequate methodological characteristics found that specialized programs to treat youth are not "…more effective for reducing sexual recidivism than general treatment as usual in juvenile justice systems."[36] Quality of the treatment program also has a significant impact on the outcomes of treatment. See appendix F for more information.

[33] Chaffin, M. (n.d.). *Reintegrating Juvenile Offenders Into the Family.* Center on Child Abuse and Neglect, Oklahoma Health Sciences Center: University of Oklahoma.
Https://nic.unlv.edu/pcan/files/Reintergrating%20juvenile%20offenders-Mark%20Chafin.pdf

[34] Association for the Treatment of Sexual Abusers (ATSA). (2014). *ATSA Adult Practice Guidelines*. Beaverton, OR.: Association for the Treatment of Sexual Abusers.

[35] Borduin, Schaeffer, & Heiblum, 2009

[36] Kettrey, H. H., & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism of juvenile sex offenders: A systematic review and meta-analysis. *Journal of Experimental Criminology*, 14(3), 361–387. https://doi.org/10.1007/s11292-018-9329-3

Treatment for general recidivism:

A large literature exists regarding effective treatment methods for probation youth generally.[37] Research has emphasized the characteristic of programs predicting effectiveness, rather than specifically identified programs. Programs should incorporate characteristics of effective treatment models which includes the following:[38]

1. The risk level and needs of the target population are assessed using reliable measures.
2. A treatment approach addresses the risk level and needs of the target population and includes a sufficient amount of treatment to be effective.
3. The treatment approach uses social skill-building, problem-solving, and counseling approaches.
4. The treatment method is manualized to reliably administer it.
5. Training and ongoing supervision and assessment is done regarding fidelity to the treatment method and quality of implementation.
6. Quality assurance checks are part of the implementation of the method.
7. Reliable outcome pre/post measures are used to assess treatment effectiveness.

Research findings indicate that generally well-designed programs for this population that are faithfully implemented with high fidelity and focus on skill-building, problem-solving, and counseling are likely to be effective. Locally developed programs can be as effective in reducing recidivism as more well-known published curriculum models.

Model programs identified as effective in reducing general recidivism with both the general population and also showing effectiveness with youth include but are not limited to the following:

a) Multisystemic Therapy[39]
b) Aggression Replacement Training[40]
c) Cognitive-Behavioral Interventions – Core (University of Cincinnati Criminal Justice Institute)[41]
d) Free Your Mind (University of Cincinnati criminal Justice Institute)[42]

[37] Lipsey et al., 2010
[38] Ralph, N. (2017, May 12). Evidence-Based Practice for Juveniles in 2017 [Blog post]. Retrieved from https://blog.atsa.com/2017/05/evidence-based-practice-for-juveniles.html
[39] Borduin, Schaeffer, & Heiblum, 2009
[40] Amendola, M., & Oliver, R. (2010). Aggression Replacement Training stands the test of time. *Reclaiming Children and Youth*, 19, 47-50.
[41] Group Interventions. (n.d.). Cech.uc.edu. Retrieved October 16, 2022, from https://cech.uc.edu/about/centers/ucci/products/interventions/group-interventions.html
[42] Pealer, J.A., Latessa, E.J., & Winesburg, M. (2002). *Final Report: Ohio RSAT Outcome Evaluation*. National Institue of Justice. https://www.uc.edu/content/dam/uc/ccjr/docs/reports/project_reports/RSAT_Summary.pdf

e) Other models may be considered including Thinking for a Change,[43] and Moral Reconnation Therapy.[44]

Strengths:

The ATSA Adolescent Guidelines (2017) recommends that practitioners design interventions that promote prosocial goals by building on existing strengths. (pg 38). Worling & Laughton (2015) identified a medium effect size from areas of strengths regarding predicting sexual recidivism for juveniles. Factors such as interpersonal strength, family involvement, school functioning, and affective or emotional strength contributed to desistance from sexual recidivism. This research and development of relevant instruments reflects a major change in this field. This change addresses strength factors for the youth as being a significant modifiable risk factor which if addressed by treatment providers would contribute to decreased sexual recidivism. Current practices describe the importance of identifying current strengths and potential strengths, and to build and support those within the natural ecology of the family and community while being respectful and supporting cultural and language factors.

Healthy Sexuality:

The ATSA Adolescent Guidelines (2017) recommends that practitioners design interventions to support healthy sexual expression and appropriate sexual regulation. Deficits in this area can be addressed through structured, developmentally and culturally sensitive curriculum. Curriculum should include: characteristics of a healthy sexual relationship, normative sexual behavior, sex related biology of the human body, safe sex practices, identification of and intervention for sexual harassment, and interventions for sexual violence.[45] ATSA's Adolescent Guidelines also note that practitioners need to focus on creating appropriate opportunities for practicing appropriate "social, courtship, and dating skills."[46] Treatment strategies should assist with problematic and potentially harmful sexual arousal, and appropriate restrictions from situations that may increase these problematic reactions.

Step-Down

Current research suggests that youth in residential settings should be stepped down to a less restrictive setting, such as community care as soon as clinically appropriate. The decision to step

[43] Bush, J. C., Glick, B., & Taymans, J. M. (1998). *Thinking for a change: Integrated Cognitive Behavior Change Program.* National Institute of Corrections.
[44] Burnette, K. D., Swan, E. S., Robinson, K. D., Woods-Robinson, M, & Little, G. L. (2004). Treating youthful offenders with Moral Reconation Therapy: A recidivism and pre- posttest analysis. *Cognitive-Behavioral Treatment Review*, 3(4), 14-15.
[45] California Department of Corrections and Rehabilitation - Division of Juvenile Justice Sexual Behavior Treatment Program (2010), unpublished.
[46] ATSA, 2017

a youth down should be made through a formal assessment of risk and need, including progress in treatment. Hunter, John A. (2012).[47]
Conducting baseline assessments and ongoing assessments are necessary for monitoring treatment progress and adjusting treatment plans. This will allow for successful tracking of progress and progression towards a step-down program. Risk assessments prior to stepping down from a residential program or discharge from community-based programs are necessary to assess which treatment needs have been resolved and what additional resources and/or supportive resources are needed.[48]

Research also suggests that the assignment and assessment of treatment goals should be connected to known risks to reoffend. Treatment completion should not be determined by factors identified to be unlikely to contribute to re-offense. These factors include items such as denial of sexual offending and low victim empathy.[49]

Effective planning is important to a successful step-down and services should be put into place prior to the actual step-down. Planning should be a collaborative process that involves the youth, his or her family when appropriate, probation, the residential treatment provider, and community provider, if care is transitioning.[50]

9. Other Documentation

Each provider agency shall maintain appropriate case documentation. These include the following: clinical records of each therapeutic contact, containment team and other collaborative team contact, notes documenting case management activities outside of the therapeutic contact, periodic progress reports, a written discharge summary, statement of successful treatment completion and any other legally required or clinically indicated written records.

All provider agencies, agency employees, such as administrative and IT personnel and providers who have access to criminal record information must meet FBI and California Department of Justice requirements by taking and passing the NexTEST exam. This must be renewed every two years. Failure to renew will lead to suspension of provider agency or provider certification, or both. Email CASOMB staff at casomb@cdcr.ca.gov for instructions.

Clinical notes for each therapeutic contact must occur. These shall include information such as client name, treatment provider name, date, time, duration of contact, client level of participation, progress towards treatment goals, treatment homework assignments, topics discussed or any risk management concerns.

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[47] Hunter, J.A. (2012). Management and Treatment Methods. In E.P. Ryan, D.C. Murrie, & J.A. Hunter (Eds.), *Juvenile Sex Offenders: A Guide to Evaluation and Treatment for Mental Health Professionals*.
[48] Righthand, S., Vincent, G., & Huff, R.M. (2017). Assessing Risks and Needs,. In S. Righthand & W.D. Murphy (Eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended.* Safer Society Press: Global Institute of Forensic Research.
[49] Rich, P. (2015). The Assessment of Risk for Sexual Re-offense in Juveniles Who Commit Sexual Offenses. *Sex Offender Management Assessment and Planning Initiative* (Report No. 251950). U.S. Department of Justice Office of Justice Programs. https://sgc.wa.gov/sites/default/files/public/SOPB/meetings/2021/somapi_full_report.pdf
[50] Hunter, 2012

Written progress reports shall memorialize the individual client's involvement in and advancement through a program. Frequency and content of any such reports should be provided to the supervising officer or agent and discussed with the supervising agency.

As each youth exits treatment, whether because treatment has been completed or for any other reason, a written discharge summary shall be prepared. This summary should include information such as the youth's participation in the treatment program, progress on goals identified in the treatment plan, strengths, and strategies to manage sexual and non-sexual risk. The reason for leaving treatment should also be stated. The discharge summary shall be provided to the probation officer.

Appendices

A. Brain, Behavioral, and Physical Development of Adolescents

Adolescence is a period of rapid physical, sexual, and brain development. For example, the grip strength of males triples from ages 10 to 18, and their weight more than doubles.[51] Testosterone affects not only physical and sexual development but also sexual drive and aggressive behaviors. Testosterone levels quadruple during this time period.[52] Secondary sexual characteristics and reproductive abilities develop rapidly.

Adolescence is a period of brain development and related behavioral maturity regarding prosocial reasoning. While the size of the brain does not change from ages to 10 to 25, the configuration of the brain pathways does. The brain is the last major organ in the body to fully develop. An area of significant development is the connections for communication for various parts of the brain. This involves in part myelination or the wrapping of brain cells with insulating materials which facilitate transmissions.[53]

The last part of the brain to develop in this way is the front part, the frontal lobes. The frontal lobes are important for judgment, impulse control, decision-making, and empathy.[54] Slowed development in this area is complemented by a rapid increase of drive and motivation to do risky or rewarding behaviors without giving adequate weight or consideration to possible adverse consequences.[55] Many problematic behaviors have the highest incidence rate during adolescence, directly connected to brain development. In all cultures youth ages 10 to 25 have the highest rate of accidents. For example, motor vehicle injuries to others where the driver was less than 25 years old are about 3 times as high compared to older age groups.[56] The highest rates for nonviolent crimes are ages 16 and 17, and are over 3 times higher than for those over 30 years of age.[57] Being on probation is strongly related to psychosocial and prosocial immaturity for adolescents.[58] For a given age, those who are less psychosocially mature are more likely to be on probation for any offense. Harmful sexual behaviors by adolescents toward children have its highest incidence at

[51] Ferreira, A.C.C., Shimano, A.C., Mazzer, N., Barbieri, C.H., Elui, V.M.C., & Fonseca, M.R. (2011). Grip and pinch in healthy children and adolescents. Acta Ortop Bras. 19(2); 92-7.
[52] Best, B. (n.d.). Mechanisms of Aging. https://benbest.com/lifeext/aging.html
[53] Jensen, F.E., & Nutt, A.E. 2015
[54] Jensen, F.E., & Nutt, A.E. 2015
[55] Steinberg, L. (2015). *Age of opportunity: Lessons from the new science of adolescence.* Mariner Books.
[56] Tefft, B.C. (2017). *Rates of Motor Vehicle Crashes, Injuries and Deaths in Relation to Driver Age, United States, 2014-2015* (Research Brief). Washington, D.C.: AAA Foundation for Traffic Safety.
[57] Canadian Centre for Justice Statistics. (2014). Youth Crime in Canda, 2014. https://www150.statcan.gc.ca/n1/pub/85-002-x/2016001/article/14309-eng.htm
[58] Stams, G. J., Brugman, D., Deković, M., van Rosmalen, L., van der Laan, P., & Gibbs, J. C. (2006). The moral judgment of juvenile delinquents: a meta-analysis. *Journal of abnormal child psychology*, 34(5), 697–713. https://doi.org/10.1007/s10802-006-9056-5

ages 13 and 14.[59] Probation involved youth who psychosocially mature are less likely to recidivate which suggests that strategies to promote this maturity should be a priority.[60]

B. Recidivism, Typologies, & Co-occuring Conditions

Rapid changes in brain development and increased psychosocial maturity in adolescents appears connected with recidivism rates for this population. Since 2000 sexual recidivism rates for Youth are estimated to be 2.75% and general criminal recidivism is 30.0%.[61] Beliefs that sexually harmful behaviors in adolescence persist at high rates into adulthood are not supported by available evidence. Likewise, sexual interest in children for does not persist for adolescents.[62] Bonner (2012) has described early adolescence, as a high-risk, transitory developmental period for committing harmful sexual behaviors.[63] Pullman and Seto (2012) note that most youth are "generalists" who engage in a variety of delinquent behaviors, rather than "specialists" engaging primarily in sexually harmful behaviors.[64] Recidivism rates for sexually harmful behaviors is comparable to similar behaviors in the general adolescent population, and one study identified that 4.8% of male and 1.3% of female adolescents engaged in coercive sexual acts.[65]

Research indicates there are both similarities and differences between juveniles who sexually offended and the general probation population. Both groups have relatively higher rates of family separations, substance abuse, criminality, and learning challenges. Youth are more likely to have higher rates of physical and sexual abuse, low self-esteem, social isolation, exposure to pornography, and poor social skills. Youth are also likely to have higher rates than the general population regarding IEPs, ADHD, substance use, trauma history, and PTSD. In turn, sexual abuse, physical abuse, dysfunctional families, learning problems, or ADHD or related disorders, if present, are associated with triple the risk of sexual recidivism.

In summary, conclusions from this research indicate treatment and disposition planning for youth needs to be designed with the awareness that recidivism is relatively low, that nonsexual recidivism is about 10 times higher than sexual recidivism, and that there is a high level of co-occurring psychiatric factors (family, ADHD, trauma, substance use, etc.). Targeting treatment of factors to reduce general recidivism and also co-occurring psychiatric factors along with a sexually-focused curriculum is essential to promote prosocial development of these youth and decrease recidivism.

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[59] Canadian Centre for Justice Statistics. (2012). Police-reported sexual offences against children and youth in Canda. https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14008-eng.htm#a8

[60] Steinberg et al. 2015

[61] Caldwell, 2016

[62] CCOSO, 2013

[63] Bonner, B. (2012). Don't shoot: We're your children. What we know about children and adolescents with sexual behavior problems. Retrieved February 20, 2017, from Boy Scouts of America, http://www.scouting.org/filestore/nyps/presentations/Children-with-SexualBehavior-Problems-Bonner.ppt

[64] Pullman, L., & Seto, M.C. (2012). Assessment and treatment of adolescent sexual offenders: Implications of recent research on generalist versus specialist explanations. *Child Abuse & Neglect*, 36(3), 203-209.

[65] Borowsky, I. W., Hogan, M., & Ireland, M. (1997). Adolescent sexual aggression: Risk and protective factors. *Pediatrics*, 100(6). https://doi.org/10.1542/peds.100.6.e7

C. Juvenile Court Transfer

Under current law, a prosecutor may make a motion to transfer a minor who is 16 or 17 years of age from juvenile court to a court of criminal jurisdiction in any case in which the minor is alleged to have committed a felony. Most youth would not be considered routinely for such a transfer, and this is usually expected to apply only in extraordinary situations. A prosecutor may also make a motion to transfer a minor who is alleged to have committed an offense listed in Welf. & Inst. Code § 707(b) from juvenile court to a court of criminal jurisdiction if the offense was committed while the minor was 14 or 15 years of age but the minor was not apprehended prior to the end of juvenile court jurisdiction.

Once the prosecution motion is filed, the juvenile court shall order the probation officer to submit a report (a social study) on the "behavioral patterns and social history" of the minor. The report is to include any statement offered by the victim. Following receipt and consideration of the probation report, and of any other relevant evidence that the prosecution and the minor choose to submit, the court must decide whether the minor should be transferred to a court of criminal jurisdiction or remain in juvenile court.

In making its decision, the court must consider specified criteria including:

a) **The degree of criminal sophistication exhibited by the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the minor's age, maturity, intellectual capacity, and physical, mental, and emotional health at the time of the alleged offense, the minor's impetuosity or failure to appreciate risks and consequences of criminal behavior, the effect of familial, adult, or peer pressure on the minor's actions, and the effect of the minor's family and community environment and childhood trauma on the minor's criminal sophistication;

b) **Whether the minor can be rehabilitated prior to the expiration of the juvenile court's jurisdiction.** The juvenile court may give weight to any relevant factor, including, but not limited to, the minor's potential to grow and mature;

c) **The minor's previous delinquent history.** The juvenile court may give weight to any relevant factor, including, but not limited to, the seriousness of the minor's previous delinquent history and the effect of the minor's family and community environment and childhood trauma on the minor's previous delinquent behavior;

d) **Success of previous attempts by the juvenile court to rehabilitate the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the adequacy of the services previously provided to address the minor's needs; and,

e) **The circumstances and gravity of the offense alleged to have been committed by the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the actual behavior of the person, the mental state of the person, the person's degree of involvement in the crime, the level of harm actually caused by the person, and the person's mental and emotional development.

The prosecutor has the burden to show, by a preponderance of the evidence, that the minor should be transferred. If the juvenile court orders a transfer to a court of criminal jurisdiction, the court must recite the basis for its decision in an order entered upon the minutes. (Assembly Bill 2361, currently pending, would require the court to find by clear and convincing evidence that the minor is not amenable to juvenile court rehabilitative efforts before a person could be transferred to criminal court. The court would also be required to recite the basis and include the reasons for its transfer decision). The statutory criteria the court evaluates in § 707(a)(3)(A)-(E) need to be viewed through the lens of the neuroscience and adolescent development. Overall trauma, i.e. exposure to violence, dysfunctional family and community environment, abuse of any kind, etc… are clearly mitigating factors for several of the statutory criteria.

While the current version of the statute doesn't use "amenability" to treatment as a criterion for determining transfer, it is likely to be the *main* factor by the end of this legislative session. Dr. Michael Caldwell, Psy.D. refers to "treatability issues" when considering the potential successful treatment of a youth who remains in juvenile court. Some of those issues include mental illness, verbal skills, taking responsibility for one's actions, general concern/care for others, family support and ability to supervise appropriately, and positive peer and community support. Presenting evidence of these positive, protective factors can provide further evidence of amenability to juvenile court interventions.

Considerations regarding these factors should be made with appropriate qualifications. For example, the research of Steinberg, Cauffman, and others, points out for example that most probation involved youth, even those with severe charges, do not go on to reoffend. In one study, only 38% of youth identified with serious criminal traits, described as psychopathy, continue to be so classified only two years later. Youth who psychosocially matured were less likely to reoffend or to have psychopathic traits. Opportunities to promote and provide treatment for psychosocial and developmental maturity are important consideration. (see Ralph, N, "Neuropsychological and Developmental Factors in Juvenile Transfer Hearings: Prosocial Perspectives." Journal of Juvenile Law & Policy, 2020).

D. Defining Scientifically Valid Instruments

Sexual recidivism risk measures: Scientifically valid instruments assessing sexual recidivism should be included. Characteristics of valid instruments include:

1. adequate interrater reliability,
2. a structured curriculum to train individuals in their use,
3. the ability of instruments to predict recidivism with at least a moderate effect size,
4. multiple replications with large sample sizes, and
5. replication by researchers other than the authors of the instruments.

E. Importance of Government Case Tracking

It is recommended that counties and the state develop a method to track case information regarding number of cases, charges, demographic information (including age and ethnic group), treatment placement and duration, and outcomes such as percent completion of treatment, and sexual and nonsexual recidivism. Management on the county basis would be improved by such information. Collecting this data on the statewide level would also assist with rational policy development in this area. At present no such system exists at a county or state level. Ideally such information would be presented to the CMT on a monthly basis to assist with case tracking.

F. Defining a Quality Treatment Program

Baglivio et al. 2018[66] evaluated 56 residential programs for probation youth in Florida.
In summary the authors note, increased treatment quality was associated with decreases in the odds of reincarceration, reoffending, and reconviction. These results support the hypothesis that the quality of the interventions delivered in a residential setting can positively affect subsequent outcomes through decreased recidivism rates.

Quality and fidelity of programs matter, not just the type of program. Program factors associated with better outcomes included adequate therapist training, a manualized treatment protocol, observed adherence to treatment models, internal fidelity monitoring, corrective action with problem situations, and evaluation of the effectiveness of the facilitator. Ideally, program outcome information would be used to modify methods to achieve greater effectiveness and assist with continuous quality improvement.

An important component is "building in" treatment progress measures, such as the one described by Righthand and associates,[67] and on a program level, to track treatment outcomes, including, but not limited to, sexual and nonsexual recidivism.

[66] Baglivio, M.T., Wolff, K.T., Jackowski, K., Chapman, G., Greenwald, M.A. and Gomez, K. (2018), Does Treatment Quality Matter?. *Criminology & Public Policy*, 17: 147-180. https://doi.org/10.1111/1745-9133.12338
[67] Prentky, R.A., Kang, T., Worling, J., & Righthand, S., (2020). *Final Report Development and Implementation Project for the Youth Needs and Progress Scale (YNPS).* U.S. Department of Justice.

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Neuropsychological and Developmental Factors in Juvenile Transfer Hearings: Prosocial Perspectives

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Introduction[1]

California, like most states, has proceedings available to transfer juveniles with criminal charges to the adult criminal justice system.[2] These proceedings are usually referred to as "transfer hearings," and they have become an important part of juvenile delinquency law.[3] In California, youths are eligible for transfer to adult court when they commit any section 707(b) offense if they are fourteen years old or older,[4] or when they commit any felony if they are sixteen years old or older.[5] The multiple issues related to transfer hearings is an emergent area of legal practice, as interpretations of the laws and strategies are still developing, and appellate decisions clarifying the law are forthcoming.

Developmental neuropsychological, brain, and forensic research are useful tools in understanding important issues related to transfer hearings.[6] One approach examines these issues using the concepts of prosocial or moral reasoning in juveniles and their relevance to juvenile delinquency and justice issues.[7] The concepts of prosocial and moral reasoning provide a conceptual framework to understand development during adolescence and explore how development relates to forensic issues, including the time-limited or adolescent specific nature of many harmful and illegal behaviors, and the treatments or interventions that can be used to accelerate prosocial reasoning to reduce recidivism.[8] The following paper reviews research in this area that are relevant to transfer hearings, and with special reference to youths with pending sexual charges. The paper discusses:

I. The teenage brain and developmental neuropsychology.

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[1] Parts of this article were adapted from with permission from RALPH NORBERT, BEING A PRO RESEARCH & THEORY MANUAL (2016).

[2] *See* CAL. WELF. & INST. CODE § 707 (West 2019).

[3] PAC. JUV. DEF. CTR. LITIGATING TRANSFER CASES 1 (14th ed. 2016) (available at pjdc.org).

[4] *Id.* at 1.

[5] *Id.*

[6] Ralph Norbert, *Moral Reasoning in Juveniles Who Sexually Offend*, 29 ATSA F. NEWSL., no. 2 (Spr. 2017).

[7] *Id.*

[8] Ralph Norbert, *Prosocial Treatment Methods for Juveniles Who Sexually Offended*, 29 ATSA F. NEWSL., no. 3 (Sum. 2017).

II. Epidemiological and community-based studies.

III. Neuropsychological assessment of social judgment.

IV. Treatments to promote social reasoning in adolescence.

V. Considerations regarding juveniles who have committed sexual offenses.

I. The teenage brain and developmental neuropsychology.

Neuropsychology and brain research provide evidence that is relevant to assessing and developing juvenile justice policies and practices. The establishment of a juvenile justice system that is separate from the adult criminal justice system, and Supreme Court decisions eliminating the death penalty and life imprisonment for juveniles, reflect the view that adolescents differ in their thinking, motivations, and prognosis regarding criminal behaviors relative to adults.[9] Developmental psychology and research on brain development provide empirically based theories that help explain the changes that occur in prosocial or moral reasoning during adolescence.[10] These theories are as basic to understanding adolescence as are the parallel physical and sexual developmental changes that take place. As youths' bodies change, their drives, interests, behaviors, and reasoning about life and relationships evolve.[11] And just as we would not treat adolescents' medical problems without knowledge of adolescent diseases, anatomy, physiology, and growth, we are wise to be similarly informed on developmental changes in prosocial reasoning relevant to juvenile justice practice and policies.

As adolescents' bodies grow and develop from ages ten to twenty-five, so do their brains, albeit in less apparent ways. In *The Teenage Brain*, Dr. Jensen[12] describes adolescent neuropsychological development.[13] Her research shows that although the size and major topography of the brain is

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[9] *See* LAURENCE STEINBERG, AGE OF OPPORTUNITY: LESSONS FROM THE NEW SCIENCE OF ADOLESCENCE 182-203 (2015).

[10] *Id.*

[11] *Id.* at 88-92.

[12] Dr. Jensen is Professor and Chair of the Department of Neurology at the Perelman School of Medicine, University of Pennsylvania.

[13] FRANCES E. JENSEN & AMY ELLIS NUTT, THE TEENAGE BRAIN (2015).

largely complete at ten years old, the interconnections and pathways of the brain continue to undergo major changes past age twenty-five.[14] For example, major changes occur in the pruning of neural pathways and myelination as brain regions continue developing.[15] Also, there is a decline in gray matter and unmyelinated cells, and a concurrent increase in white matter and neural pathways, indicating that lesser-used neurons are pruned and existing neural pathways, including those governing prosocial actions, are strengthened.[16] Jensen references the National Institute of Mental Health in summarizing brain development in the first twenty-one years of life, noting that the teenage brain is only about 80% mature by age twenty-one, and the outstanding 20% is the difference between being an adolescent and a prosocial adult.[17] Thus, the process of growing into a well-functioning adult is partly related to the maturation of the brain.

Dr. Kevin Powell conceptualizes these developments in a similar fashion.[18] He compares brain development in teens to creating trails across an unfamiliar territory.[19] Initially, in getting from Point A to Point B, youths can take an infinite number of routes.[20] But with time and experience, youths use certain trails more than others.[21] These trails become the youths' "habits" and "go to" strategies, and they are wired in as youths' continue maturing, reflecting a decrease in brain cells and connections.[22] Thus, if a teen copes with a stressful situation by reacting impulsively, minimizing responsibility, and blaming others, this can become a template for dealing with life problems.[23] But the same can be true of prosocial patterns of behavior, where youths find successful strategies to meet their own needs while not breaking social rules or laws.[24]

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[14] *Id.* at 57-58.
[15] *Id.* at 60.
[16] *Id.* at 58.
[17] *Id.* at 37.
[18] KEVIN M. POWELL, WORKING EFFECTIVELY WITH AT-RISK YOUTH: A STRENGTHS-BASED APPROACH 69-91 (2011).
[19] *Id.* at 71.
[20] *Id.*
[21] *Id.* at 73.
[22] *See id.* at 73-4 (highlighting importance of youth repeatedly practicing "healthy alternative" options).
[23] *See id.* at 73 (stating unused pathways become less prominent as individuals age).
[24] *See id.* at 73-4 (referring to youth's health alternative choices).

Dr. Ken Kiehl's neuropsychological research on brain development in adolescents is also relevant. Using neural imaging techniques in the form of functional MRIs (fMRIs), Kiehl compared the brains of male youths on probation and not on probation, against average adult brains.[25] From this, he developed a measure that he termed "brain age," which allowed him to predict the chronological age of general population adolescents with reasonable accuracy by just examining their fMRIs.[26] He found that juveniles on probation had brains that appeared five to ten years less mature than juveniles not on probation.[27] Kiehl attributed these differences in the brains of probation-involved juveniles to immaturity, rather than cognitive or physical deficits, or differences in brain structures.[28]

Dr. Laurence Steinberg also discusses pertinent research in his book *The Age of Opportunity*.[29] There, he describes adolescence as an important period of brain plasticity for the development of prosocial behavior, during which physical, and familial and peer relational changes complement brain changes.[30] He then conceptualizes adolescence as a period of increased drive and activity of the reward centers of the brain;[31] increased risk-taking;[32] increased strength, height, weight, and physical abilities;[33] increased mobility, including the ability to drive;[34] decreased supervision and control by parents and schools;[35] association with risk-taking youth and a strong need to fit in with these peers;[36] increased access to alcohol and drugs that decrease inhibition and judgment, and increase risk-taking

[25] Kent. A. Kiehl et al., *Age of Gray Matters: Neuroprediction of Recidivism*, 19 NEUROIMAGE CLINICAL 813, 813-23 (2018).
[26] *Id.* at 814.
[27] *Id.*
[28] *Id.*
[29] STEINBERG, *supra* note 8.
[30] *Id.* at 5.
[31] *Id.* at 73.
[32] *Id.* at 93.
[33] *See generally id.* at 52 (discussing hormonal changes that occur during puberty).
[34] *See, e.g., id.* at 46.
[35] *See id.* at 62 (discussing how schooling "stimulates the development of high-order cognitive abilities and self-control in ways that simply getting older does not").
[36] *Id.* at 93.

behaviors;[37] critical development of judgment and control centers of the brain that regulate or put the brakes on impulsive behavior.[38]

Dr. Abigail Baird and associates have also done germane research on problem-solving skills and brain development in adolescents.[39] Their research examined how adults and teens think about novel situations, such as riding a bicycle down stairs.[40] While adults in the study utilized visual processing areas of the brain, teens used prefrontal areas of the brain that are associated with planning and judgment.[41] Baird and associates attributed this difference between teens and adults to research suggesting that prefrontal areas of the brain do not fully mature until age twenty-five.[42] In another article, Baird and Fugelsang discussed the development of counterfactual reasoning in adolescents, which involves thinking about "what if" and "then what" possibilities, and constructing alternative scenarios based on different assumptions about life situations.[43] Thus, counterfactual reasoning is similar to what Piaget, originator of the cognitive-developmental paradigm, described as the emergence of abstract thinking in adolescence.[44] Baird and Fugelsang note:

> What does the development of counterfactual reasoning mean for the justice system? One direct implication of this model is that young adolescents may lack the neural hardware to generate behavioural alternatives in situations demanding a response. For example, adolescents are more likely than most adults to engage in risk-taking behaviour. While there are a myriad of theories about why this is the case (see Spear, 2002, for an extensive review), one reason for increased risk-taking in adolescents might be their inability to generate alternatives and potential outcomes

[37] *See id.* at 89 (noting that adolescents are "more likely than other age groups to experiment with alcohol, cigarettes, and illicit drugs").
[38] *Id.* at 70-71.
[39] BAIRD & FUGELSANG, THE EMERGENCE OF CONSEQUENTIAL THOUGHT: EVIDENCE FROM NEUROSCIENCE 1797-1802 (2004).
[40] *See id.*
[41] *Id.* at 1801.
[42] *Id.*
[43] *See* BAIRD & FUGELSANG, *supra* note 38, at 1797-804 (discussing counterfactual reasoning).
[44] *Id.* at 1797, 1800.

> prior to the initiation of behaviour. More specifically, a great number of adults think about driving their cars at excessive speeds, and while some adults do engage in this behaviour, adults are more likely to also envision a number of counterfactual scenarios that vary in their desirability. This is an important component of appreciating potential consequences of actions.[45]

Counterfactual thinking is a major area of development during adolescence. It provides youths with the ability to consider a range of prosocial behavioral alternatives. Generally, parents "coach" their teens to think about aspects of a situation they did not consider. For example, "If you ask your friend Carlos, but not John, to go to the movies, how will John feel?" Or, "If you don't study now, you will be too tired to get up early and do it?"

II. Epidemiological and community-based studies.

As noted above, Steinberg describes adolescence as a period of heightened potentiality and vulnerability due to a confluence of factors[46] that are complemented by judgment that has not reached adult levels.[47] In *Fourteen: the most dangerous age*,[48] Richard Alleyne notes that teens experience positive reinforcement when they face known risks and succeed, and he describes the peak age for risk-taking as fourteen.[49] Both Steinberg and Alleyne go on to note the "health paradox" of adolescence, wherein adolescence is the healthiest stage of life in terms of morbidity, but also the riskiest in terms of various health and behavioral measures, including the frequency rate of accidents.[50] Steinberg also describes a related phenomenon, the "accident hump."[51] He notes:

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[45] *Id.* at 1801.

[46] STEINBERG, *supra* note 8, at 15.

[47] *See* JENSEN, *supra* note 12, at 38 (discussing how "teens are not quite firing on all cylinders when it comes to the frontal lobes, we shouldn't be surprised by the daily stories we hear and read about tragic mistakes and accidents involving adolescents").

[48] *See* Richard Alleyne, *Fourteen: the most dangerous age*, TELEGRAPH (Mar. 24, 2010), https://www.telegraph.co.uk/news/science/science-news/7511842/Fourteen-the-most-dangerous-age.html.

[49] *See id.*

[50] *See id.*; STEINBERG, *supra* note 8, at 15-16.

[51] STEINBERG, *supra* note 8, at 49.

> In all cultures and times, the mortality rate among boys spikes a few years after they become adolescents. It's called the 'accident hump,' and it occurs because the rise in testosterone that takes place at puberty makes males more aggressive and reckless. That makes them more likely to do things that get them killed, like picking fights or doing risky things on a dare.[52]

Adolescence is a stage of life in which several harmful behaviors are at their highest, as evidenced in the classic "Age-Crime Curve."[53] Relatedly, Figure 1 shows the peak age of those accused of theft and robbery in Canada is seventeen.[54] And Figure 2 shows the peak age of those accused of sexual offenses involving children is three to four years earlier.[55] Surely statements regarding causal factors related to the shape or comparison of these curves would most rigorously be made from longitudinal studies using actual case information and analysis.[56] However, the data represented in Figures 1 and 2 is consistent with the neuropsychological research described above.

Based on Figure 1, theft appears to have both the highest incidence and the steepest "peak" of any crimes.[57] At seventeen, youths have adult-like physical abilities, increased mobility, and decreased supervision, but lack maturity in social reasoning areas requiring "if-then" and "cost-benefit" thinking that inhibit impulsive decisions.[58] Likewise, the development of such thinking progresses rapidly and is consistent with the

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[52] *Id.*

[53] David P. Farrington, *Age and Crime*, 7 CRIME AND JUST.: A REV. OF RES. 189, 191-200 (Michael Tonry ed., 1986) (discussing how the Age-Crime Curve suggests harmful behaviors are at their highest during adolescence).

[54] Mary Allen, *Young adult offenders in Canada, 2014*, 36 JURISTAT 1, 8 (2016), https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2016001/article/14561-eng.pdf?st=ZbsUpckq.

[55] Adam Cotter & Pascale Beaupré, *Police-reported sexual offences against children and youth in Canada, 2012*, 34 JURISTAT 1, 13 (2014), https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2014001/article/14008-eng.pdf?st=3UT1dwa0.

[56] *Id.*

[57] Allen, *supra* note 54, at 8.

[58] *See, e.g.*, Part __, supra. [the discussion of "The teenage brain and developmental neuropsychology,"]

rapid decline in thefts and robberies after age seventeen.[59] In contrast, the curve's peak for Figure 2 occurs three to four years before Figure 1's, at ages thirteen to fourteen, when most males have adult-like sexual capabilities and drives, but lack maturity in social judgment.[60] This rapid decline may be due to brain maturation, especially in areas of the brain involving judgment and that apply the "brakes" to behavior.[61] Indeed, Steinberg believes that the developmental changes that occur in the prefrontal cortex, the area primarily responsible for self-regulation, and the limbic system, the area responsible for emotion and what persons find rewarding, partly explain the curves in both figures.[62]

Other criminological research further supports the idea that adolescence is a high-risk but transitory period for criminal behaviors, including the Orange County study, which tracked 3000 juveniles using data from 1987.[63] The study revealed that 71% of the juveniles did not have a new probation referral during the initial three-year study period;[64] that 21% of the juveniles went on to commit one or two additional offenses during the study period;[65] and that a small percentage of juveniles (8%) committed at least three additional offenses during the study period.[66] The latter youths accounted for more than half of the repeat offenses committed.[67]

Steinberg, Cauffman, and Monahan studied 1,300 serious juvenile offenders for seven years after their convictions.[68] For their study, they developed a measure of psychosocial maturity that included impulse control, aggression control, consideration of others, future orientation, personal responsibility, and resistance to peer influences. Consistent with

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[59] Allen, *supra* note 54, at 8.

[60] Adam Cotter & Pascale Beaupré, *supra* note 55, at 13.

[61] *See id.*

[62] *See* STEINBERG, *supra* note 8, at 70 (discussing how brain changes that occur in adolescence lead to emotional changes).

[63] Gwen A. Kurz & Louis E. Moore, *8 Percent Problem Findings*, OC PROBATION (Mar. 1994), http://www.ocgov.com/gov/probation/about/8percent/findings.

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] Laurence Steinberg, Elizabeth Cauffman & Kathryn C. Monahan, *Psychosocial Maturity and Desistance From Crime in a Sample of Serious Juvenile Offenders*, JUV. JUST. BULL. 4 (U.S. Dep't Just. Off. Juv. Just. and Delinq. Preven., Mar. 2015).

current research on brain maturity, they found their measure of psychosocial maturity increased through age twenty-five.[69] Moreover, they found that less than 10% of the sample of serious offenders could be characterized as chronic offenders.[70] Even the majority of high frequency juvenile offenders in the study stopped offending by age 25.[71] But levels or recidivism did vary depending on psychosocial maturity: less mature individuals were more likely to be persistent offenders; and psychosocially mature, high-frequency offenders were more likely to desist from criminal behaviors.[72] Thus, their study linked psychosocial maturity to desistance from crime. They also posited that factors that derail or delay psychosocial development may contribute to continued criminal behavior. And they suggested that policymakers should assess policies, sanctions, and interventions based on whether they promote or inhibit psychosocial maturity.[73]

In a 2016 study, Cauffman, Skeem, Dmitrieva, and Cavanagh assessed the stability of psychopathy in 202 male juveniles and 134 adult males housed in secure detention facilities.[74] The researchers used adult and juvenile versions of the Hare Psychopathy Checklist, in which psychopathy refers to a set of characteristics associated with antisocial behavior, including selfishness, callousness, impulsiveness, rule breaking, violence, and using others without guilt.[75] The researchers measured psychosocial maturity using a standardized composite of self-rating scales.[76] They found there was a greater risk of exaggerating psychopathic traits among juveniles than adults;[77] that 37% of juveniles who met the cut score for psychopathy continued meeting the criteria years later, compared to 53% of adults;[78] and that false positive errors were more common among the youngest and least

[69] *See id.* at 6 (noting that "at age 25, most of the individuals who had been high-frequency offenders when they were in middlescence were no longer committing crimes").
[70] *Id.*
[71] *Id.*
[72] *Id*. at 8.
[73] *See id.* at 9 (suggesting that "if responses to juvenile offenders slow the process of psychosocial maturation, in the long run these responses may do more harm than good").
[74] Elizabeth Cauffman et al., *Comparing the stability of psychopathy scores in adolescents versus adults: How often is "fledgling psychopathy" misdiagnosed?*, 22 PSYCHOL., PUB. POL'Y, & L. 77, 80 (2016).
[75] *See id.* at 81.
[76] *Id.*
[77] *Id.* at 84.
[78] *Id.* at 85.

psychosocially mature juveniles.[79] Additionally, increased psychosocial maturity predicted lower psychopathy scores in adolescents but not adults.[80] These findings suggest that caution should be exercised when using the construct of psychopathy with adolescents, especially when making sentencing decisions based on such findings.

The findings in this section are consistent with the view that most adolescent crime is time-limited and not part of a universal pattern of behavior for all adolescents. The findings are also consistent with research on brain development discussed above that relates the desistance of criminal behavior and psychopathy to increases in psychosocial maturity.[81] In short, as the brain matures, criminal acts decrease sharply in frequency, and more so when psychosocial maturity increases.

III. Neuropsychological assessment of social judgment.

Additional psychological research support the above findings on the teen brain and the development of prosocial reasoning, including its relation to adolescent delinquency.[82] Using meta-analysis, Stams et al. reviewed fifty studies on juvenile delinquency and social reasoning, using measures of moral reasoning.[83] The analysis revealed lower levels of moral reasoning in delinquent youths compared to nondelinquent youths (effect size = 0.76).[84] The researchers concluded that developmentally delayed social reasoning or moral judgment was strongly associated with juvenile delinquency, even after controlling for socioeconomic status, gender, age, and intelligence.[85] They also found that production measures that required youths to articulate information rather than just choose options produced a

[79] *Id.*

[80] *Id.* at 84.

[81] *See id.* at 86.

[82] Geert Jan Stams et al., *The Moral Judgment of Juvenile Delinquents: A Meta-Analysis*, 34 J. ABNORMAL PSYCHOL. 697, 697 (2006) (analyzing 50 studies that deal with juvenile delinquency).

[83] *Id.*

[84] Effect size is a standardized statistic to quantify the difference between two groups, such as an experimental and control. One mathematical definition of it is: Effect size= (Mean of experimental group) - Mean of control group)/ Standard Deviation. An effect size of .20 is described as small, .50 is medium, and .80 is large. An everyday example given is that the difference in height between 14 and 18-year-old girls can be described as a medium effect size, that is clearly visible to the eye. Robert Coe, *It's the effect size, stupid: What is effect size and why it's important* 12-14 (Ann. Conf. Brit. Educ. Res. Ass'n, Sept. 2002).

[85] Stams et al., *supra* note 82, at 697.

larger difference between delinquent and non-delinquent youths.[86] The researchers attributed this difference to respondents having to generate moral reasoning responses, rather than recognize moral reasoning responses, which allowed researchers to more directly examine respondents' moral thinking.[87]

Also, the author of this article conducted unpublished research using the Roberts 2 test on probation and normative samples.[88] The Roberts 2 test uses pictures as the stimulus for youths to create stories about everyday life situations in order to generate and gather samples of their social reasoning.[89] The samples were matched for age and ethnicity, with sixty-six youths on probation and sixty-eight youths from a nonclinical sample.[90] Scales included Problem Identification, which refers to the sophistication and complexity of how problem situations are defined, and Resolution, which defines the sophistication with which problems are resolved.[91] Generally, these developmental measures increase in the general population with age.[92] Summaries of the Problem Identification and Resolution scales were used to see if youths on probation could be differentiated from the normative sample.[93] The data revealed that youths on probation were approximately six years behind in their social reasoning development as compared to youths not on probation—the area under the curve for Problem Identification (0.92) and Resolution (0.88) were consistent with a large effect size.[94]

Another research investigated prosocial development using the Prosocial Reasoning Outcomes (PRO) instrument, which measures youths' social reasoning sophistication and complexity about everyday life situations based on their responses to questions about vignettes.[95] The

[86] *Id.*
[87] *Id.* at 698.
[88] Norbert Ralph, *Practical Prosocial Methods for Assessment and Treatment of Juveniles with Sexual Offending Behaviors, in* SEXUALLY ABUSIVE BEHAVIOR IN YOUTH: A HANDBOOK OF THEORY, ASSESSMENT, AND TREATMENT, at 19-17 (Barbara K. Schwartz, ed., 2017).
[89] *Id.*
[90] *Id.* at 19-18.
[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id*. at 19-22 to 19-25.

instrument is still in development, and the findings reported here should be considered provisional, pending subsequent confirmation.[96] The instrument is designed to discriminate between impulsive decisions, and those for which the consequences and rationale for behaviors are described.[97] Three groups of youths participated in the study: a group of high school youths not on probation (HS); and two groups of youths placed by probation in residential placements for sexual offenses.[98] One placement housed youths with a medium level of risk for sexual recidivism (ML), and another housed youths who on average had a high level of risk for sexual recidivism (HL).[99] Higher PRO scores indicated more mature levels of social reasoning. The results showed a perfect rank order among the three groups, with the HL group ranking lowest, and the HS group ranking highest (HL=1.73, ML=2.27, and HS=2.73).[100] This indicated the PRO instrument could distinguish youths not on probation from those in medium and high level residential programs for juveniles who sexually offend, and could presumably describe differences in their level of prosocial reasoning relevant to their group status.[101]

The discrepancy in PRO scores indicates that while developmental immaturity in prosocial reasoning is associated with delinquent behaviors, as individuals mature and their prosocial reasoning increases, they are less likely to engage in harmful criminal behaviors.[102] Thus, this research complements the neuropsychological and epidemiological research discussed above.

IV. Treatments to promote social reasoning in adolescents.

There is substantial research showing that adolescents' social reasoning and judgment can be reliably assessed, and research showing that treatment methods can promote adolescents' levels of social reasoning, which are associated with decreased criminal recidivism.[103] For example, the Washington State Institute for Public Policy assessed effective

[96] *See id.* at 19-2, 19-24.
[97] *Id.* at 19-24 to 19-25.
[98] *Id.* at 19-24.
[99] *Id.* at 19-24 to 19-25.
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Id.*

treatments for juvenile justice populations using meta-analysis.[104] It yielded significant evidence that strategies that promote social skills and reasoning during adolescence, which the study's authors described as cognitive behavioral interventions, had a significant positive outcome.[105] Indeed, from a "cost-benefit" point of view, for every dollar spent on cognitive behavioral interventions, there was a $38.40 return in social benefits.[106]

One of the most comprehensive research examining the general juvenile probation population is Dr. Lipsey's and his colleagues' meta-analysis.[107] Their approach identified several factors connected with positive outcomes for treatment methods for juveniles on probation.[108] They found that methods that used skill building and counseling to promote social reasoning were the most effective.[109] Moreover, complementary research showed that the fidelity with which programs are administered impacts their effectiveness.[110] Lipsey further found that even for youths with severe offenses, out-of-home placements for those with significant mental health problems were less effective than nonresidential options and could do more harm than good.[111] Indeed, residential or secure detention placements did not provide an improvement in treatment outcomes.[112] Lipsey writes:

> In practical terms, juvenile justice systems will generally get more delinquency reduction benefits from their intervention dollars by focusing their most effective and costly interventions on higher risk juveniles and providing less

[104] WASH, ST. INST. FOR PUB. POL'Y, BENEFIT-COST RESULTS: JUVENILE JUSTICe. (2018), *available at* http://www.wsipp.wa.gov/BenefitCost/Pdf/1/WSIPP_BenefitCost_Juvenile-Justice (demonstrating the costs and benefits of various juvenile justice programs using meta-analysis).

[105] *Id*.

[106] *Id.*

[107] *See* MARK W. LIPSEY ET AL., IMPROVING THE EFFECTIVENESS OF JUVENILE JUSTICE REFORM: A NEW PERSPECTIVE ON EVIDENCE-BASED PROGRAMS, 21-23 (Georgetown Univ. Ctr. for Juvenile Justice Reform 2010).

[108] *See id.* at 24-25.

[109] *See id.* at 24.

[110] *See* Pauline Brigitta Goense et al., *Making 'What Works' Work: A Meta-Analytic Study of the Effect of Treatment Integrity on Outcomes of Evidence-Based Interventions for Juveniles with Antisocial Behavior*, 31 AGGRESSION & VIOLENT BEHAV., 106, 106 (2016) ("[M]eta-analytically examined the effect of treatment integrity on client outcomes of evidence-based interventions for juveniles with antisocial behavior.").

[111] *See* LIPSEY, *supra* note 107, at 14, 23.

[112] *Id.* at 23.

> intensive and costly interventions to the lower risk cases. Moreover, they can expect similar benefits from their intervention programs for juveniles at a given risk level whether they are treated and supervised in the community or in residential facilities.[113]

Optimistically, Lipsey notes that "there was no indication that there were juveniles whose risk level was so high that they did not respond to effective interventions." [114]

In another research, Dr. Caldwell and associates developed a treatment unit for youths who failed treatment in Wisconsin's secure detention placements because of repeated violence and noncompliance.[115] Dr. Caldwell's secure detention model emphasized rewards over punishment based on his research findings and clinical experience that punishment did not work with violent and noncompliant youths, but rewards did. [116]

The results showed that youths with severe aggressive and noncompliant behaviors had less recidivism if they received specialized treatment in detention, a model the researchers termed "decompression therapy."[117] In fact, youths receiving "decompression therapy" had a recidivism rate of 10%, in contrast to the control group which had a recidivism rate of 70%.[118]

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[113] *See id.* at 14.

[114] *Id.* at 23.

[115] *See* Michael F. Caldwell, *Efficacy of a Decompression Treatment Model in the Clinical Management of Violent Juvenile Offenders*, 45 INT'L J. OF OFFENDER THERAPY & COMP. CRIMINOLOGY, 469, 469 (2001) [hereinafter Caldwell, *Efficacy of a Decompression Treatment Model*] (Finding decompression treatment used on " highly disruptive and aggressive, incarcerated juvenile offenders" reduced criminal recidivism); *See also* Michael F. Caldwell, *Evidence of Treatment Progress and Therapeutic Outcomes Among Adolescents with Psychopathic Features*, 34 CRIM. JUST. & BEHAV., 573, 575 (2007) [hereinafter Caldwell, *Evidence of Treatment Progress*] ("[E]xamined the relation between psychopathic features and treatment progress in a group of 86 delinquent boys.").

[116] *See, e.g.*, Caldwell, *Efficacy of a Decompression Treatment Model*, *supra* note 115, at 473; Caldwell, *Evidence of Treatment Progress*, *supra* note 115, at 577.

[117] *See* Caldwell, *Efficacy of a Decompression Treatment Model*, *supra* note 115, at 471-73; Caldwell, *Evidence of Treatment Progress*, *supra* note 115, at 576-77.

[118] *See* Caldwell, *Efficacy of a Decompression Treatment Model*, *supra* note 115.

V. Considerations regarding juveniles who committed sexual offenses.

Are developmental factors in social reasoning also relevant to the subgroup of youths on probation who sexually offend, and thus relevant to the issue of transfer hearings for this group? The Canadian data in Figure 2 shows epidemiological data on age and sexual offending.[119] It shows that sexual offenses peak at age thirteen to fourteen and then decline to about a sixth of this rate at age twenty-seven. Dr. Barbara Bonner, in reviewing similar epidemiological data, concludes that early adolescence is a high risk but transitory period for committing sexual offenses.[120] Indeed, that sexual crimes peak two years earlier than theft or robbery suggests that immaturity in social judgment may play a greater role in committing sexual offenses than other juvenile crimes. Though males are not the sole perpetrators of sexual crimes, their physiological capacity to commit them at age thirteen or younger[121] is relevant to understanding the peak in the age-crime curve.

There are additional considerations with this subgroup. As a clinician who has evaluated and treated sex offending youths for nearly two decades, it is especially important to assess the rate of sexual recidivism in sex offending youths since it is often the primary reason why these youths are on probation. Even in cases where youths face multiple charges, the severity of sexual offenses are often the most germane in disposition hearings. Research Michael Caldwell found that the rate of sexual recidivism for juveniles has been 2.75% since 2000.[122] This rate is consistent with my experience from doing trainings with probation departments in over twenty counties throughout California in the past few years. While sexual crimes are among the most serious, recidivism for juvenile sexual crimes is very low.[123] In fact, a follow-up study of 129 youths in residential treatment for juveniles who sexually offended found

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[119] Allen, *supra* note 54, at 7.

[120] *See* Barbara L. Bonner, Don't Shoot: We're Your Children. What We Know about Children and Adolescents with Sexual Behavior Problems at the National Youth Protection Symposium Boy Scouts of America (Nov. 1-2, 2012).

[121] *See Male Puberty*, SEXINFO ONLINE, http://www.soc.ucsb.edu/sexinfo/article/male-puberty (Feb. 20, 2016).

[122] Michael F. Caldwell, *Quantifying the Decline in Juvenile Sexual Recidivism Rates*, 22 PSYCH. PUB. POL. & L. 414, 419 (2016) [hereinafter Caldwell, *Quantifying the Decline*] (examining the decline of "the recidivism base rate for juvenile sexual recidivism" in recent decades).

[123] *See id.* at 414.

that none of the juveniles were on public sex offender registries 4.1 years after they turned eighteen.[124]

Because of the seriousness of sexual offenses and severity of harm to victims, juveniles in California who sexually offend are frequently referred for transfer hearings. The underlying logic may be that since the youths committed a serious crime, they are best dealt with in the adult criminal justice system. Various arguments can be advanced for this position, including that sexual crimes are among the most heinous and reflect an underlying propensity for a persistent pattern of sexual criminal behaviors that are unlikely to change. But the research discussed above suggests that rehabilitation in a juvenile justice context is possible and more effective than the punitive measures used in the adult criminal justice system. Still, there are some individuals whose risk to public safety is significant, and decisions regarding their disposition need to be made on an individual basis.

Research on moral or prosocial reasoning among juveniles who sexually offended parallels the research on deficits found in the general probation population compared to those in the general non-probation population.[125] For example, the PRO instrument described above distinguished youths in high and medium probation groups from those in a non-probation group.[126] Further, a research team investigating the moral development of juvenile male sex offenders and non-offenders found lower stages of moral judgement among offenders.[127] My own research has also found delays in moral reasoning in juveniles who sexually offended compared with juveniles not on probation.[128]

There is also evidence regarding the effectiveness of treatment for juveniles who sexually offended that parallels the research done with the general probation population described above.[129] Indeed, the author of this

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[124] Ralph, *Practical Prosocial Methods for Assessment and Treatment of Juveniles with Sexual Offending Behaviors*, *supra* note 88, at 19-10.

[125] *See* Stams et al., *supra* note 82, at 697.

[126] *See* Nobert Ralph, *An Instrument for Assessing Prosocial Reasoning in Probation Youth*, 11, SEXUAL OFFENDER TREATMENT, no. 1, 2016 (demonstrating the differing effects of the PRO on probation and no probation groups), *available at* http://www.sexual-offender-treatment.org/150.html.

[127] *See* Eveline Van Vugt et al., *Moral Development of Solo Juvenile Sex Offenders*, 14, J. OF SEXUAL AGGRESSION, no. 2, at 99-109 (2008).

[128] Ralph, *Practical Prosocial Methods for Assessment and Treatment of Juveniles with Sexual Offending Behaviors*, *supra* note 88.

[129] *Id.*

paper conducted three studies using Aggression Replacement Training (ART) on juveniles who sexually offended.[130] The ART model promotes moral or prosocial reasoning, and numerous studies have documented its effectiveness in reducing recidivism among juveniles on probation.[131] Amendola and Oliver summarize those studies by noting that ART is a "Model Program" for the United States Office of Juvenile Justice and Delinquency Prevention, and the United Kingdom Home Office.[132] The author's first study involved a randomized trial that looked at psychological outcomes, and it found a positive treatment effect for ART.[133] A subsequent study in 2012 replicated these findings, but it did not include a control group.[134] The findings supported the hypothesis that ART contributed to therapeutic changes on psychological outcomes for these youths.[135] Furthermore, a longitudinal study showed that ART reduced the level of sexual acting out in juveniles in a residential program for juveniles who have sexually offended.[136] Additionally, the author of this paper developed an intervention to promote prosocial reasoning in juveniles who sexually offended, and he found that it increased measures of prosocial reasoning and behavior among these juveniles.[137]

Although the preceding studies had several methodological limitations, other research on the effectiveness of treatments for juveniles who sexually offended complement their results. Reitzel and Carbonnel

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[130] *See* Nobert Ralph, *A Follow Up Study of a Prosocial Intervention for Juveniles who Sexually Offend*, 10, SEXUAL OFFENDER TREATMENT, no. 1, 2015, *available at* http://www.sexual-offender-treatment.org/140.html; *see also* Nobert Ralph, *A Longitudinal Study of Factors Predicting Outcomes in a Residential Program for Treating Juveniles Who Sexually Offend*, 10, SEXUAL OFFENDER TREATMENT, no. 2, 2015, *available at* http://www.sexual-offender-treatment.org/145.html.

[131] Mark Amendola & Robert Oliver, *Aggression Replacement Training Stands the Test of Time*, 19 RECLAIMING CHILD. AND YOUTH J., at 47-50 (2010) (explaining the positive effects of ART).

[132] *Id.* at 48.

[133] Ralph, *A Follow Up Study of a Prosocial Intervention for Juveniles who Sexually Offend*, *supra* note 130.

[134] *Id.* (summarizing the previous study done in 2012).

[135] *Id.*

[136] *See* Nobert Ralph, *A Longitudinal Study of Factors Predicting Outcomes in a Residential Program for Treating Juveniles Who Sexually Offend*, 10, SEXUAL OFFENDER TREATMENT, no. 2, 2015, *available at* http://www.sexual-offender-treatment.org/145.html.

[137] See Nobert Ralph, *A Validation Study of a Prosocial Reasoning Intervention for Juveniles Under Probation Supervision*, 11, Sexual Offender Treatment, no. 2, 2016, *available at* http://www.sexual-offender-treatment.org/157.html [hereinafter Ralph, *A Validation Study*].

provide an authoritative summary of this area of research.[138] Every study in their research showed a positive treatment effect.[139] Performing meta-analysis on other meta-analytic studies, Kim, Benekos and Merlo studied the effect size of treatments on recidivism for juvenile and adult sex offenders.[140] They identified a medium effect size for adolescent programs (-0.51) and a small effect size for adult programs (-0.14).[141] This indicated that treatment programs for those who sexually offended had a larger effect size for juveniles compared to adults.[142] This finding is consistent with the hypothesis that these treatments are more effective with adolescents than adults, presumably due to adolescents' brain plasticity and capacity for prosocial development—as described above.[143]

Summary

The above literature review presented research and theory relevant to juvenile transfer hearings. It should be noted that the research cited had methodological limitations that limit the generalizability of their findings. For example, not all research had multiple replications, by different authors, and with large sample sizes, as is preferable in statistical research. With that noted, several qualified conclusions appear reasonable:

1. The peak age for violent and nonviolent offenses over a lifespan is late adolescence.[144] Immaturity in social reasoning is a crucial developmental risk factor for criminal behavior.[145] This is a trait that can be reliably assessed.[146] The peak age for sexual offenses

[138] *See generally* Lorraine Reitzel & Joyce Carbonell, *The Effectiveness of Sexual Offender Treatment for Juveniles as Measured by Recidivism: A Meta-Analysis*, 18, SEXUAL ABUSE: A J. OF RES. & TREATMENT, at 401-21 (2006) (studying the results of a meta-analysis about effects of treatments for juveniles).

[139] *Id.* at 413.

[140] *See generally* Bitna Kim et al., *Sex Offender Recidivism Revisited: Review of Recent Meta-Analyses on the Effects of Sex Offender Treatment,* 17, TRAUMA, VIOLENCE, & ABUSE, no. 1, at 105–17 (2015) (examining effect sizes across different age populations and effect sizes across various sex offender treatments).

[141] Stams et al., *supra* note 82.

[142] *Id.* at 88.

[143] See the discussions above for more information.

[144] *See* Kim et al., *supra* note 140, at 107; *see also* Stams et al., *supra* note 82, at 700.

[145] *See* Stams et al., *supra* note 82, at 697; *see also* Kim et al., *supra* note 140, at 107.

[146] *See* Stams et al., *supra* note 82, at 697; *see also* Kim et al., *supra* note 140, at 107.

appears to be two years younger than that for offenses such as theft.[147]

2. Social reasoning in adolescence increases over time, appears to be a risk factor for delinquency, and distinguishes probation from non-probation groups, including those who sexually offended.[148] While the rate of violent crimes rises dramatically during adolescence, it declines significantly in late adolescence and young adulthood, again presumably in part due to maturing prosocial reasoning skills.[149]

3. Significant evidence exists that treatment methods can increase youths' levels of prosocial reasoning, which is associated with decreased criminal recidivism, even for youths at the highest level of risk.[150] While the passage of time itself will on average reduce an individual's risk of recidivism, an appropriate type and amount of prosocial treatment can accelerate this process.[151] Not all treatments are equal, however. Treatments that are shown to be effective, implemented with high fidelity, and appropriately targeted, have the best chance of successful outcomes.[152]

4. The findings described above for the general probation population are also applicable to the subset of juveniles who sexually offended.[153] An additional consideration with this population is the low risk of recidivism for sexual offenses, about 3%, though their total recidivism is likely 10 times higher.[154] The earlier peak age of incidence for sexual crimes and the low recidivism for juveniles who sexually offend support the argument that developmental factors are perhaps more important for this subgroup than for the general juvenile

147 *See* Stams et al., *supra* note 82, at 700; *see also* Kim et al., *supra* note 140, at 107.

148 *See* Stams et al., *supra* note 82, at 700 (arguing that juvenile repeat offenders invoke morality standards to minimize the badness of their behavior).

149 *See id.*

150 *See* Kim et al., *supra* note 140, at 107 (stating that juvenile sex offenders that receive treatment have low rates of reoffending).

151 *Id.* at 114 ("One of the most promising findings is that every meta-analysis in this review found significant recidivism reduction outcomes.").

152 *See id.*

153 *See id.*; Stams et al., *supra* note 82.

154 Caldwell, *supra* note 122, at 419 ("The 33 studies conducted over the past 15 years reported a mean sexual recidivism rate of 2.75%.").

> delinquent population.[155] Sexual offending, for most, is not a lifetime, highly prevalent, or persistent problem.[156]

The above literature review has implications for decisions concerning transferring juveniles to the adult justice system. With regard to California, according to the analysis of the Pacific Juvenile Defenders Center, the central issue to consider is a youth's amenability to treatment within the juvenile justice system.[157] Both Caldwell's and Lipsey's research described above identified no population of delinquent juveniles where treatment failed to produce a significant effect when adequately administered.[158] In Caldwell's study, taking arguably the "worst of the worst" from juvenile prisons in Wisconsin, youths receiving specialized treatment had a recidivism rate of 10%, compared to the control group's higher rate of 70%.[159] Disposition planning, of course, always needs to be individualized. However, based on current research, it is difficult to discern what public good would be served by transferring juveniles to the adult justice system if the goals are to improve public safety and rehabilitate individuals. There is no evidence supporting the efficacy of this transfer policy, and a reasonable conclusion is that youths are likely to have much poorer outcomes in the adult justice system.

The focus of this article has been on moral or prosocial development, but other psychological factors may be relevant in transfer hearings. For example, a Florida study with a large juvenile probation population found that 50% of the juveniles had a history of significant disruptive or traumatic childhood experiences.[160] Also, as I have documented elsewhere, there is a high incidence of comorbid psychiatric, learning, substance abuse, and attentional problems for youths in the criminal justice system.[161] All these might be considered under the heading of "mitigating factors" in transfer hearings.

Moreover, the literature obliquely supports two notions: first, that effective evidence-based treatments depend on accurate evidence based-

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[155] *Id.* at 419; *see* Stams et al., *supra* note 82, at 700.

[156] Caldwell, *supra* note 122, at 419.

[157] Pac. Juv. Def. Ctr., *supra* note 3.

[158] *See* Lipsey et al., *supra* note 107; Caldwell *supra* note 122.

[159] Caldwell, *supra* note 122, at 2-3.

[160] Michael T. Baglivio et al., *The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders,* 3 OJJDP 1, 1-23 (2014).

[161] Ralph, *A Validation Study*, *supra* note 137.

assessments, and comprehensive psychological and neuropsychological evaluations tailored for "high-risk" youths; second, that successful outcomes depend on appropriate treatments being faithfully given in appropriate doses. In transfer hearings, sometimes someone will suggest that a youth is not amenable to treatment because the youth was previously treated, and problematic behaviors continued. Yet, in all the cases I have reviewed, the youths were never given an adequate type or amount of treatment. Instead, youths were commonly undertreated, not treated at all, or treated with the wrong method.

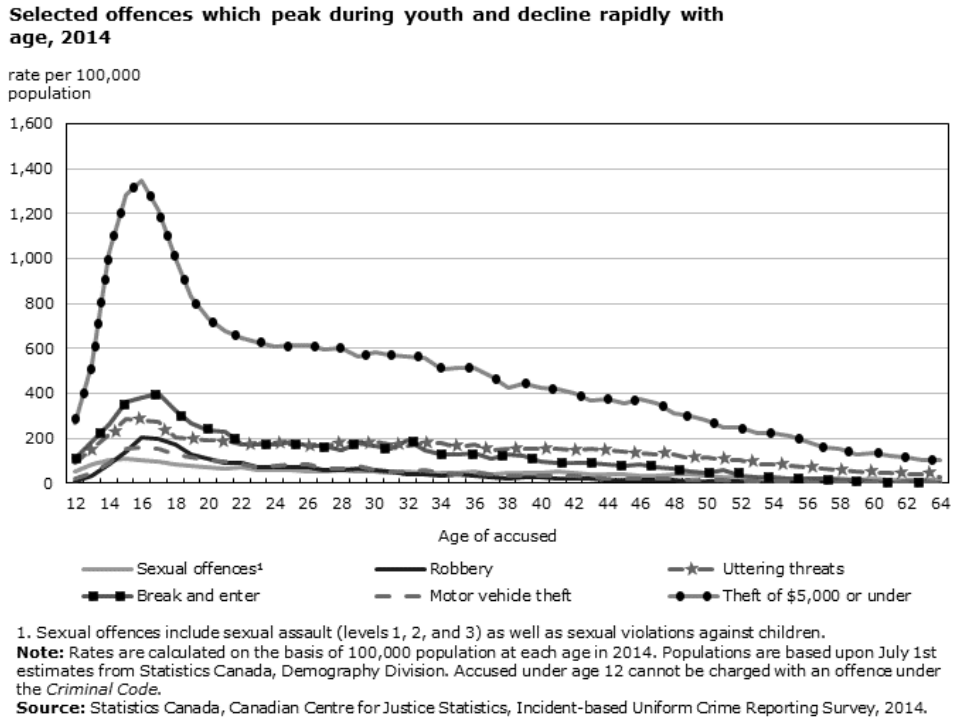


Figure 1: Canadian Age- Crime Curve. Source: Statistics Canada, *Young adult offenders in Canada*, 2014. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.

Mary Allen, *Young adult offenders in Canada*, 2014, 36 JURISTAT 1, 8 (2016), https://www150.statcan.gc.ca/n1/en/pub/85-002x/2016001/article/14561-eng.pdf?st=ZbsUpckq.

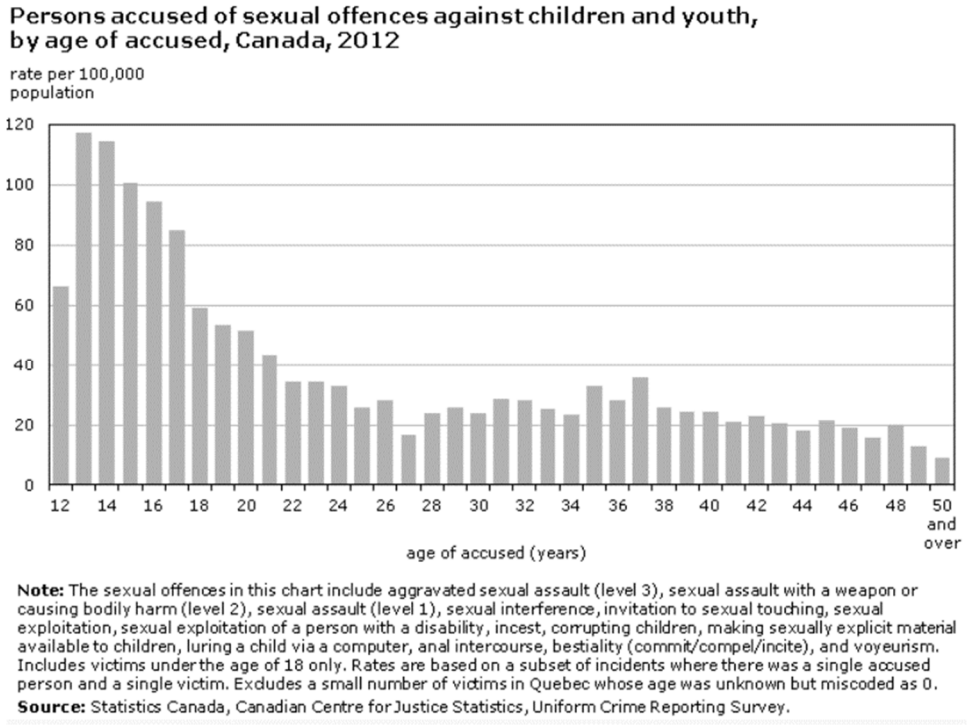


Figure 2: Ages of those accused of sexual offenses against children and youth. Source: Statistics Canada, Police-reported sexual offences against children and youth in Canada, 2012, 2014. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.

Adam Cotter & Pascale Beaupré, Police-reported sexual offences against children and youth in Canada, 2012, 34 JURISTAT 1, 13 (2014), https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2014001/article/14008-eng.pdf?st=3UT1dwa0.

ATSA Blog...
Association for the Treatment & Prevention of Sexual Abuse

Friday, June 21, 2024

Responsivity and Reading in Adolescents

By **Norbert Ralph, PhD, MPH**

Best practices for the treatment of youth with problematic sexual behavior (YPSB) include the use of the principles of risk, need, and responsivity. The last of these, the responsivity principle, is described by ATSA (2017) as interventions that take into account personal strengths, developmental stage, education, and motivation. As a neuropsychologist who assesses learning disabilities, I believe that an important part of assessment and also treatment planning is to understand the reading level of a youth. Written materials are routinely part of treatment including consents, worksheets, and workbooks. Some relevant information was provided by a survey of California adolescent treatment providers (Ralph, 2013) which identified that 41.9% used, for example, Pathways by Kahn (Kahn, 2011).

What are reading levels in YPSB? Lewis, Shanok, and Pincus (as cited in Ferrara and McDonald, 1996) compared juveniles who had sexually offended with another juvenile population with violent but nonsexual offenses. They found the two groups did not differ on IQ testing regarding full-scale, verbal, or performance measures. However, they found that juveniles with sexual offenses scored 5.59 years below grade level and the comparison group 3.95 years.

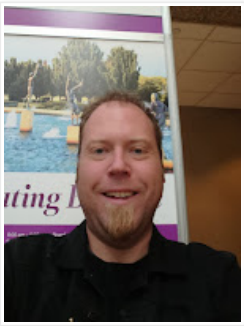
In my clinical experience reading levels can be readily assessed using reading tests in less than 10 minutes. As an administrator for psychological testing for the juvenile courts in San Francisco, I found few psychologists in court-ordered testing would choose to assess reading levels. They didn't view this as part of their role even though this information wasn't available readily in any records. I found many youth that I assessed as having a reading disorder that had not previously been identified through the school system. I was careful to make sure such youth were referred for an IEP assessment and possibly specialized services to help promote their educational and prosocial development.

Reading level has profound implications not only in a youth's ability to use written curriculum but their academic and life experiences. Many occupational and even social opportunities are limited due to reading levels and this also has an impact on the youth's self-image and view of future life possibilities. One study found that youth identified with a reading disorder at age 7 were 56% less likely to obtain a higher income than those with average or above reading skills (McLaughlin, Speirs, & Shenassa, 2014). Authoritative guidelines for youth specifically recommend an assessment that includes reading level (California Sex Offender Management Board, 2022).

Understanding the reading level of materials for youth is important in several respects. Reading levels can be estimated using such measures as the Flesch–Kincaid Grade Level (FKGL) which can be calculated using a computer. This measure gives an estimate of the grade reading level of documents and was used by the U.S. Army to rate the difficulty of technical manuals (Wikipedia, 2023).

The readability of written materials is relevant in several areas. Youths routinely sign consent to treatment or release of information forms. These forms should be comprehensible to most youth. For example, one California County's consent form had an FKGL of 11.0 and the authorization for the release of protected health information was 11.5. A private practice group's adolescent consent form had an FKGL of 12.7.

Kieran McCartan, PhD



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It's also important to consider the reading level of workbooks or materials for juveniles since this will be an indicator of how well they can be understood and used. For illustrative purposes, several workbooks were analyzed using this methodology. One well-designed workbook available as a PDF online had an FKGL of 7.5. A sample chapter on controlling impulses from a widely used workbook had an FKGL of 7.1. A workbook by the author, Being a Pro, (Ralph, 2016) had a FKGL of 5.5. For comparison, the reading level of this document is 12.7.

Let's use the upper and lower limits of this very modest sample, with a FKGL of 5.5 and 7.5 grade levels to consider comfortable reading levels for the average 14-year-old juvenile on probation whose approximate grade level would be 8.0. Using the data from Ferrara and McDonald (1996) and the estimate of juveniles on probation being four years below grade level in reading, then the average reading grade level of the 14-year-old on probation would be 4.0. According to broader educational research, such as Chall and Conard (1991), students who are proficient readers can read at a level one to one and a half grades above their current grade. So if treatment reading material had an FKGL of 5.5, the average probation youth in this hypothetical scenario could comprehend this material but not one with an FKGL of 7.5.

In summary, an important part of the responsivity principle is assessing the reading level of youth in treatment and also additionally the reading level required by consent and treatment methods. A mismatch in these areas would likely lead to less successful outcomes.

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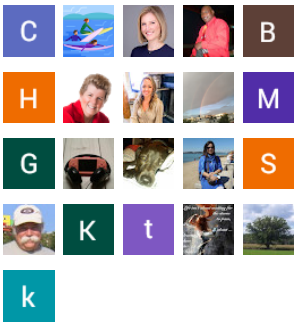

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