Research Article

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Juveniles with Sexual Behavior Problems: A Treatment Program Evaluation

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Abstract: Juveniles commit a significant portion of the sexual abuse perpetrated on other children. Treatment for juveniles with sexual behavior problems has moved from modified adult treatments to more developmentally appropriate approaches. Although cognitive-behavioral therapy is the most commonly used approach, research indicates that inclusion of significant others in the juvenile's life is important when working with these youth. The inclusion of the juvenile's family is seen as especially vital in treatment success. The current article reviews treatment outcomes, as measured by recidivism (re-offense) rates, for juvenile males completing a county juvenile sex offender treatment program. The program emphasizes family involvement and collaboration with juvenile probation officers, correctional officer, attorneys, and judges in the ongoing treatment as well as support of the juvenile and his/her family. Results indicate a sexual recidivism rate of 7.2% which is consistent with meta-analyses of research on sexual recidivism in treatment programs. The recidivism rate for non-sexual crimes was 33.7%, which is lower than typically reported in meta-analyses of treatment outcomes. The treatment program was equally effective for all juveniles, regardless of race.

Keywords: juvenile sex offenders, multi-systems therapy, family therapy

Since the 1970s there has been an ever increasing recognition that juveniles commit a significant portion of sexual abuse perpetrated on other youth (Davis & Leitenberg, 1987; Fehrenbach, Smith, Monastersky, & Deisher, 1986; Finkelhor, Ormrod, & Chaffin, 2009; Fortune & Lambie, 2006; Veneziano, Veneziano, & LeGrand, 2000). Almost 40% of all child sexual abuse is perpetrated by youth under the age of 20 (Finkelhor, Ormrod, & Chaffin, 2009; Oliver, 2007; Pithers & Gray, 1998). Findings such as these, coupled with retrospective studies of adult sexual abusers who reported that they started abusing children when they were adolescents, led many to believe that sexual behavior problems follow a developmental trajectory of continuing sexually abusive behavior throughout adolescence and adulthood (Abel et al., 1987; Burton, 2000; Zolondek, Abel, Northey, & Jordan, 2001). If juvenile sexual offenders typically follow such a developmental trajectory, one would assume that most of these juveniles would exhibit a pedophilic sexual orientation that is likely to continue into adulthood. However, analysis of the literature does not support this assertion. Juveniles with sexual behavior problems are a heterogeneous population (Seto & Lalumiere, 2010) and the engagement in a sexual offense does not predict general patterns of sexual offending in the future (McCuish, Lussier & Corrado, 2015). Many juveniles engage in sexually abusive behavior because of curiosity, naivety, immaturity, poor age-appropriate socialization, and other factors that do not lead to continued sexual offenses in adulthood (Andrade, Vincent, & Saleh, 2006). Researchers have found re-arrest rates for registered juvenile sex offenders in adulthood to be as low as 5% (Vandiver, 2006), with reviews of the literature suggesting recidivism rates below 10% for those who received some type of treatment (Parks & Bard, 2006).

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Reitzel and Carbonell (2006) conducted a meta-analysis of treatment studies on recidivism rates among juveniles in sex offender treatment programs and found a 7.37% sexual recidivism rate for juveniles completing treatment as compared to 18.93% sexual recidivism rate for juveniles in comparison (non-treatment) groups. The overall recidivism rates indicated significantly more non-sexual recidivism rates than sexual recidivism rates. They found that overall recidivism rates (treatment and comparison groups) were 12.53% for sexual crimes, 24.73% for violent-nonsexual crimes, 28.51% for non-violent crimes, and 20.4% for other unspecified crimes. Kahn (2015) reported that past research typically found rates between about 20 and 60% for non-sexual re-arrests among juveniles treated for sex crimes, with younger children showing re-arrest rates at the lower end and adolescents at the higher end of this range. These findings indicate that juvenile sex offenders are more likely to recidivate with a non-sex crime than a sex crime.

Although any recidivism causes concern, especially given the devastating nature of child sexual abuse on the victim (Chapman, Dube, & Anda, 2007), the recidivism rates for juveniles charged with a sex crime is significantly lower than juveniles charged with other crimes. Almost six out of 10 juveniles exhibiting other criminal/delinquent behavior are rearrested (Snyder & Sickmund, 2006). It appears that recidivism for juveniles engaging in sexually abusive behavior is much lower than recidivism for other types of juvenile crime, especially for those who receive sex offender treatment.

It is important to note that there is concern about recidivism rates in that they typically rely on re-arrest rates (some studies have examined self-reports of recidivism and not just re-arrest) and many sex crimes do not get reported (Fortune & Lambie, 2006; Ikomie, 2008). It has been estimated that as many as 25 sex crimes are committed for each arrest (Elliott, 1995). In addition, follow-up periods for reporting recidivism are often too short to determine the extent of recidivism as persons may not be immediately caught or the person may not re-engage in offending behavior until a longer period of time has elapsed (Ikomie, 2008).

However, there is compelling evidence that youths charged with sexual offenses who receive treatment actually show significantly fewer sexual offenses after the treatment (Chaffin et al., 2008; Letourneau, Chapman, & Schoenwald, 2008; Reitzel & Carbonell, 2006), and a greater number of studies is being completed that include longer periods of follow-up in order to better assess recidivism across time. Carpentier, Silovsky, & Chaffin (2006) conducted a treatment follow-up study and found low sexual recidivism rates even 10 years after treatment. Youth who had been in treatment for sexual behavior problems exhibited no more sexual behavior problems 10 years later than a control group of youth who did not have sexual behavior problems. In other words, after treatment, youth with previous sexual behavior problems did not engage in more sexually inappropriate behavior than other youth who had not previously shown any sexual behavior problems.

Borduin and colleagues compared multisystemic therapy (MST) with treatment-as-usual (individual and group outpatient therapy) among a group of high risk juvenile sexual offenders. In this 8-year follow-up study they found a sexual recidivism rate of 8% for MST and 46% for treatment-as-usual, with a non-sexual recidivism rate of 29% and 58%, respectively (Borduin, Schaeffer, & Heiblum, 2009). The striking finding of this study was the positive impact on family functioning, peer interactions, and school performance. Other studies have found that juvenile sex offenders, as well as juveniles with other offenses, experience difficulties in family, peer, and school situations (Pithers & Gray, 1998; Ronus & Borduin, 2007; Van Wijk et al., 2005). These findings highlight the importance of including multiple systems in any treatment program and discourage focusing on the juvenile in isolation from their family and community. Indeed, a recent review of evidence-supported treatments for juveniles with sexual behavior problems found that only MST can be considered an evidence-supported therapy with sex offending juveniles (Dopp, Borduin, Rothman, & Letourneau, 2017). The authors indicated that although cognitive-behavioral therapy is the primary therapy used in most treatment programs, it does not have sufficient empirical support to be included as an evidence-supported treatment with these youth. These authors also indicate that the inclusion of family and other stakeholders (e.g., juvenile probation officers and judges) is beneficial for reducing both sexual and non-sexual recidivating.

Inclusion of the family in any treatment protocol is especially important. Parental involvement is significant because of many family influences (e.g., parental stress, parental mental health problems, and family attitudes towards sexuality) on juvenile sexual behavior problems (Bonner, Walker, & Berliner,

1999; Friedrich, et al., 2001; Halse et al., 2012; Silovsky & Niec, 2002; Underwood, Robinson, Mosholder, & Warren, 2008; Worling, Litteljohn, & Bookalam, 2010). In addition, insights and skills parents attain in treatment are vitally important to the success of treatment. Meta-analyses of the treatment literature find that family involvement and parenting skill are better predictors of successful outcomes for youth with sexual and nonsexual behavior problems than any general treatment approach (e.g., cognitive-behavioral therapy, play therapy), especially with younger juveniles (Lipsey, 2009; St. Amand, Bard, & Silovsky, 2008).

The current study was conducted as an evaluation of a county sex offender treatment program. The study assessed the recidivism rates of juveniles who completed the sex offender treatment program. The program includes a team-based approach with input from therapists, correctional officer, juvenile probation officers, judges, and attorneys.

Method

Participants

A review of detention records yielded 83 juveniles between the ages of 10 and 16 years ($M=13.8$, $SD=1.53$) who were placed in the county juvenile detention center for a sexual offense. The sexual offenses included sexual assault and indecency with a child. Most youth who are adjudicated in the county for a sex crime are referred to the county detention center to participate in the sex offender treatment program. However, some juveniles with supportive extended families (i.e., juveniles who have other family members with whom to stay when the victim, such as a younger sibling, is in the home) and no other extenuating circumstances may complete outpatient treatment. What is more, some juveniles who have other violent offenses in addition to any sex crime or exhibit a violent sex crime on an adult may be sent to a state correctional facility. There were originally 99 males and two females who had been sent to the detention center's sexual offender treatment program. However, 16 males and both females sent to the program refused to participate or adhere to detention behavior guidelines and were sent to state detention facilities. Because these youth had been sent to state facilities, no other data beyond anecdotal reporting from detention personnel was available for them (records had been sent to the state and were not made available for the current assessment), including lengths of time in the program before being sent to state facilities. Anecdotal reporting was that most of those youth had been removed within the first few weeks due to detention center behavior violations, but because of lack of verifiable information the current analysis included those 83 males who completed the program. Of the 83 males who completed the program, 69 were white, 13 were black, and one was categorized as "other." We evaluated the recidivism rates (ranging from one to three years, median two years, after the treatment) for these 83 juvenile males who completed the juvenile sex offender treatment program.

Materials

The current study was conducted from recidivism data in archived detention records of juveniles adjudicated for sexual crimes. The program evaluation outcome assessment was approved by the county juvenile detention superintendent and chief juvenile judge and presented to the juvenile board for approval. Detention records were reviewed and examined by the director of juvenile detention and the lead juvenile probation officer for accuracy of the data. All data were then de-identified before being analyzed for the current study. Therefore, the identities of the individual juveniles were unknown to the current authors. The descriptions of the program elements and treatment team are presented below.

Treatment program. The Texas Council on Sex Offender Treatment (the licensing body for sex offender treatment providers) indicates that the primary goal of treatment is to have no further victims, with public safety outweighing other considerations in treatment. With both a therapeutic and public safety mandate, the two-year program is seen as both correctional (i.e., detention) and treatment-focused (i.e., provide intensive treatment while in detention). The treatment program includes mental health and correctional

personnel in the overall program. The county juvenile program involves a holistic approach to treating juveniles with sexual behavioral problems that encompasses both individual and family therapy along with intervention from therapists, probation officers, correctional officers, and the juvenile court system.

The juvenile sexual offender program was designed to treat juveniles who have been adjudicated with a sexual crime. All juveniles who are incarcerated for a sex crime complete a two-year program in the detention center. As detailed in Table 1, the treatment includes five basic components – Relapse Prevention, Victim Empathy, Developing Healthy Social Relationships, Learning Healthy Sexuality, and Supervision.

Table 1. Treatment Components and Goals

Component	Goals
Relapse Prevention	identify thinking, emotional, behavior, and family patterns, identify cognitive distortions, identify cycles of thoughts, feelings, and behaviors, identify triggers, identify red flags, know safety plan
Victim Empathy	identify impact of sexual abuse to victim, show emotional understanding of impact on victim, victim reparation (when appropriate), tell of own victimization (when appropriate)
Developing Healthy Social Relationships	establish positive relationships with: family members, same-age peers school (peers, teachers, administration), authority figures (probation officer, police, etc.)
Learning Healthy Sexuality	boundary awareness. understand issues of consent, build relationships, understand rules related to appropriate sexual interaction, manage fantasies appropriately, exhibit positive sexuality
Supervision	by parent / guardian / significant other, by juvenile probation officer. by treatment provider, self-management skills

In treatment, each juvenile and their family members receive education and counseling related to all five components. The juveniles are incarcerated in the county detention center and receive daily skills training, weekly group therapy sessions, weekly individual therapy, and a minimum of twice a month family therapy. The parents or guardians of these youth participate in weekly multi-family group therapy, and the aforementioned family therapy with their child. Family sessions are conducted in-person. Family participation is included in the court orders, and juvenile probation officers work with parents to encourage their involvement in all phases of treatment.

Treatment team. The juvenile sex offender program was designed as a holistic approach to treatment. Therefore, not only is the juvenile and his/her family included in therapy, but the treatment team also includes professionals throughout the juvenile justice system. All persons in the system, including correctional officers, juvenile probation officers, attorneys, and judges, received training on working with juveniles with sexual behavior problems. In Texas, all licensed therapists who provide treatment to persons who sexually offend must be a licensed sex offender treatment provider (LSOTP), which requires licensure in another mental health specialty (e.g., psychologist, social worker), 40 hours of continuing education, and supervision from an approved LSOTP supervisor. LSOTPs must also receive ongoing continuing education in sex offender assessment and therapy (24 hours per biennium). Although not required by the state, correctional officers and juvenile probation officers in this treatment program attend training conferences

on working with juveniles with sexual behavior problems every year. The primary judges working with these juveniles received initial training at a sex offender conference. Attorneys receive ongoing education about sex offender issues during the monthly staff meetings. Both the primary judge assigned to these cases and attorneys have presented at conferences together with the program's director, who is an LSOTP.

The program director and the family therapist conduct the individual, group, and family therapy sessions, while the correctional officers conduct specific skills training groups, such as self-management skills. Staff meetings are held on a monthly basis and include the lead therapist, other counselors, juvenile probation officers, correctional officers, and county attorneys assigned to the cases. Information regarding each juvenile is discussed in the staff meetings, with the goal of making sure everyone has input and is aware of progress and goal attainment for each individual. In addition, updates on progress are discussed formally with the parents or guardians monthly and the talk usually includes the lead therapist and juvenile probation officer.

Procedure

We examined the treatment outcomes (completion rates, recidivism rates, and comparison of effectiveness of treatment for youth of differing races) for the sex offender treatment program for the 83 juveniles who completed the two-year program between 2010 and 2015. We used archival data from the juveniles' detention records to determine the program completion and recidivism. It is important to note that juveniles who had their records sealed or expunged were not included in the data. Juveniles who successfully complete the program and have no other arrests for any crime, either sexual or non-sexual, are eligible to have their official arrest records sealed or expunged at age 19. These arrest records are not automatically sealed. Records are only sealed for those juveniles who have no further crimes and actively seek to seal their records. Once records are sealed, there can be no access to them. Therefore, although we knew that a number of adolescents who had been through the program had successfully petitioned to have their records sealed, meaning that they had not recidivated prior to age 19, we did not have access to their juvenile records. Without direct access to the records, we did not include those juveniles in any of the current data. As a result, the number of juveniles who did not is higher than we captured in our data.

We examined the recidivism rates in four categories. The first category was no reported re-arrest for any crime. The second category was re-arrest for a non-sex crime (e.g., smoking marijuana, theft). The third category was for a re-arrest for a non-sex, but sexually related, offense, such as looking at pornography, violating the conditions of probation (sexual in nature, but not a sex crime). The fourth category was sexual re-offense, such as another sexual contact with a minor. This final category is what most researchers report when identifying sexual recidivism rates. Because there is no control group available in the county (i.e., all juveniles in the county are sent to treatment), we used a benchmarking procedure (see Hunsley & Lee, 2007) by comparing the results to two often-cited meta-analyses of juvenile sex offender treatment.

Results

The four categories examined for recidivism included no recidivism, non-sexual recidivism (e.g., theft), sexually related probation violation (e.g., viewing pornography), and sexual recidivism (e.g., sexual assault). The rates for each category were as follows:

- no recidivism – 54.2%,
- non-sexual recidivism – 33.7%,
- sexually-related probation violation recidivism – 12%,
- Sexual recidivism – 7.2%.

Using the data from meta-analyses by Reitzel and Carbonell (2006) and Caldwell (2010) on treatments of juvenile sex offenders, we compared the recidivism rates reported by those studies with the rates found in the current program using two-sample t-tests between percents and Cohen's *d* for effect sizes (see Table 2).

Because the reports from other studies include sexual and non-sexual recidivism rates and not sexually-related probation violations (e.g., looking at pornography) as done for the current evaluation, Table 2 includes comparisons for sexual and non-sexual recidivism. In addition, Table 2 includes comparisons between the current program and the past research on juveniles with sexual behavior problems who either received or did not receive treatment. The comparison with the other treatment outcomes allows for a comparison of the effectiveness of the current juvenile sex offender treatment program to other treatment programs.

Table 2. Comparison of recidivism rates

Recidivism	Current JSO Program	Studies reported by Reitzel and Carbonell (2006)	Studies reported by Caldwell (2010)	t-Test (two-sample t-test between percents) and Cohen's d Results	Summary of Results
Sexual (youth receiving treatment)	7.2%	7.37%	7.08%	Comparison with studies analyzed in Reitzel and Carbonell: $t(1736)=0.058$ $p=.95$ $d=.003$ Comparison with studies analyzed by Caldwell: $t(11300)=0.042$ $p=.96$ $d=.001$	There is not a significant difference between these groups. The Current JSO Program is equivalent to other successful treatment programs reported in published research.
Sexual (comparison of treatment outcomes in current program to a set of youth who did not receive treatment)	7.2%	18.93%	No data reported	$t(1412)=2.685$ $p=.007$ $d=.143$	There is a significant difference between the two groups with the Current JSO Program having significantly lower recidivism rate than a no-treatment comparison.
Non-sexual	33.7%	73.64%	43.4%	Comparison with studies analyzed in Reitzel and Carbonell: $t(2645)=8.01$ $p<.00001$ $d=.311$ Comparison with studies analyzed by Caldwell: $t(11,300)=1.777$, $p=0.076$ $d=.033$	The current program had the lowest non-sexual recidivism rate. There is a significant difference between the current JSO Program and studies analyzed by Reitzel and Carbonell, but there is not a significant difference between the current program and the studies analyzed by Caldwell.

Table 2 indicates that the current juvenile sex offender (JSO) Program is consistent with the other published outcome studies regarding the effectiveness of treatment with regards to low sexual recidivism rates for youth who complete the treatment program. In comparison to youth who receive no treatment (using data from other studies as the comparison group), the current JSO Program is showing significant treatment effects, and it appears to be also significantly better than no treatment (procedure/protocol/) in reducing sexual recidivism. The current program has notably lower non-sexual recidivism rates than the studies presented by Reitzel and Carbonell (2006). However, it is important to note that the comparison rate for non-sexual re-offense crimes reported by Reitzel and Carbonell was much higher than reported by many studies. They computed rates from violent, non-violent and "other" non-sexual re-offenses, but there may be an overlap in some of the rates for which they did not account. In order to more fully assess the current JSO Program we also used recidivism data from Caldwell (2010). This data allowed for a more

conservative comparison between the non-sexual recidivism rates. Caldwell's meta-analysis found a non-sexual recidivism rate of 43.4%. In comparing that to the current program's non-sexual recidivism rate, there was not a significant difference. Although the non-sexual recidivism rate for current program is lower than the average from the meta-analysis of the other programs analyzed by Caldwell (33.7% vs. 43.4%), it is not statistically significantly lower.

Because some research has suggested that there may be racial differences in treatment outcomes for sexual behavior problems, we also compared recidivism rates within the program to see if there were significant differences between different youth's success and failure within the program (no recidivism, non-sexual, sexual-related, or sexual). The results of a comparison between youth (white, black, and "other") found no significant differences in outcomes, $X^2(6) = 2.71, p = 0.16$. This indicated that the treatment program was equally effective for all youth in the program.

Discussion

The recidivism outcome data from the program supports previous findings that juveniles who complete a sex offender treatment program exhibit low recidivism rates. The juveniles who completed this program had a 7.2% sexual recidivism rate, which is consistent with meta-analyses of other programs' success rates (average sexual recidivism rates in the meta-analyses of multiple treatment programs were 7.37% and 7.08%). The results also indicate that the current treatment program is significantly better than no treatment control groups cited in the recent meta-analyses. These results suggest that the current treatment program may be an effective intervention for juveniles with sexual behavior problems.

The results indicated a non-sexual re-offense rate of 33.7%. Although this may seem high, this rate is actually lower than the findings of other studies treating adolescent sex offenders. Juveniles arrested for sexual offenses are more likely to have non-sexual re-offenses (e.g., theft, drug use) than sexual re-offenses. Indeed, some research indicates that non-sexual re-offense rates run as high as 60% for all juveniles who have been arrested, regardless of whether the original arrest was for a sexual or non-sexual crime (Snyder & Sickmund, 2006). Therefore, the lower non-sexual re-offense rates in the current study are extremely important when evaluating the overall success of treatment in reducing all types of re-offending by these youth.

Another important finding from the current outcomes, and one which is often overlooked in the research literature, is that males of different ethnic and racial backgrounds benefited from treatment. Ikomi and colleagues found differences between white, black, and Hispanic male juvenile sexual offenders on issues such as the youths' history of being abused, incidences of sexual offenses, distrust of the juvenile justice system, and other factors that could impact treatment with these youth (Ikomi, Rodney, & McCoy, 2009; Venable & Guada, 2014). As a result it becomes vitally important to show which treatments are effective with youth from different backgrounds. Most of the research has focused on white male youth, who also constituted the majority of the adjudicated sex offenders in the current study. Although the number of participants is relatively low, both white and black males in this program evaluation were equally successful in completing the treatment. Because of the low number of females adjudicated for sex crimes (only two in the current database, neither of whom completed the program), there continues to be a dearth of information on effective treatment for females.

The current program did not differentiate between subtypes of juvenile sex offenders. Fox and DeLisi (2017) found four subtypes of male juvenile sex offenders – non-disordered, impulsive/unempathetic, early onset chronic, and victim offenders. The research is not clear as to whether different treatment approaches are better for different subtypes of juvenile offender. It is not known whether all four subtypes were represented in the current data or whether certain subtypes did better in the program. Since most treatment programs are like the current program in that they must take all juveniles who are sent by the courts, it is not possible to accept only certain subtypes of juvenile offenders into the program. However, future research about which aspects of treatment, if any, may be most efficacious for which subtypes of juvenile sex offender will help treatment providers better tailor treatment to each juvenile subtype.

It is also important to note that not all juveniles who were adjudicated for a sex crime were referred to the treatment program. Although most youth who are adjudicated in the county for a sex crime are referred to the treatment program, some juveniles with more family support are treated in an outpatient setting, while those with additional violent offenses or sex crimes perpetrated on an adult are sent directly to the state juvenile corrections system. Further examination of offender rehabilitation needs, such as through the risk-need-responsivity (RNR) model by Andrews and colleagues (Andrews, Bonta, & Hoge, 1990; Andrews, Bonta, & Wormith, 2011), may help judges and treatment teams better target intervention strategies for these youthful offenders.

Another limitation to the current data is that we could not include juveniles who had completed the program, reached age 19, and so were able to get their juvenile records sealed. These were adolescents who had not committed another crime and were able to get their juvenile records sealed or expunged. Those juveniles would have been counted as having not recidivated, which would have lowered the recidivism rates (both sexual and non-sexual). Because the files were sealed, we did not have access to any of those records and there was no clear basis for estimating the number of sealed files; therefore, we did not run a sensitivity analysis to assess for recidivism rates if those youth had been included as not recidivating. However, the recidivism rates for both sexual and non-sexual offenses would be lower given that these juveniles were able to get their records sealed.

The current treatment program for juveniles with sexual behavior problems highlights the importance of everyone working together for the safety of the community and the treatment of the youth. Parents and other family members participated in the treatment, and their inclusion was seen as vital to the success of the program. During the therapy, family members examined maladaptive patterns within their own families, and they were also able to make changes to help their child or adolescent transition effectively back into the home. These findings are consistent with the research regarding the importance of including family and other stakeholders in treatment (Dopp et al., 2017).

What is unique to the program is that all professionals involved receive training about juveniles with sexual behavior problems. Therapists are licensed as sex offender treatment providers. Correctional officers and juvenile probation officers are specially chosen to work with these youth and receive ongoing professional education on juvenile sex offenders. Prosecuting attorneys and judges also receive training in juvenile sex offender treatment and have even conducted professional workshops with the therapists. The collaborative nature of the program was seen as especially important for the cohesiveness of the treatment team as well as reducing concerns among the family. Although parents' concerns about the juvenile justice system are seldom taken into consideration, studies indicate that parents involved in juvenile court are often distrustful of the system and feel alienated from those making decisions about their child (Rose, Glaser, Calhoun, & Bates, 2004; Varma, 2007). Including parents in the process and having all professionals aware of treatment and supervision issues appeared to increase parent participation and accountability and to reduce their distrust across time.

The length of treatment is a major consideration in treatment of youth with sexual behavior problems. Reviews of published studies have found that treatment periods of less than a year, often in outpatient or community settings, are sufficient for positive outcomes and low recidivism rates (Dopp et al., 2017). The current program is longer and it is set in a detention facility. Important considerations for length and intensity of such treatment come from community standards and the criminal justice system. As noted previously, the primary stated goal of any treatment program in Texas is to have no further victims, with public safety outweighing other considerations in treatment. Detention is a punishment in the criminal justice system. The current treatment program was designed to provide treatment within that framework. As mentioned earlier, some juveniles in the county participate in outpatient counseling whereas those with more disrupted family situations or serious offenses are sent to the detention program. In some cases, the victim's families petitioned for detention sentencing. An important element of the detention treatment program for youth who successfully complete the program is that they do not have to register as a sex offender. Therefore, although the length of treatment is longer than reported in some treatment literature, the program is viewed as successful within the county juvenile justice system.

The current program evaluation gives clinicians and correctional facilities a programmatic blue-print

that shows success. Although the current data does not allow for examination of the specific contribution of each component of the program, it is possible that specific elements of the program contribute to the juveniles' success while other components do not. However, the present findings are consistent with previous research in confirming the importance of holistic or multi-systems approaches. Cognitive-behavioral approaches have become the *sin qua non* of juvenile sex offender treatment, and cognitive-behavioral techniques are used in the current program. In addition, this study also indicates the importance of examining systemic issues with family and others. Indeed, the holistic approach of including the family, correctional officers, juvenile probation officers, attorneys, and judges appears to be a vital component for reducing both sexual and non-sexual recidivism and reintegrating into the community. Future research needs to further examine the importance of such collaboration. While examination of different treatment approaches, such as cognitive-behavioral, systems, or other treatment approach is important, looking at collaboration among different professionals and encouraging sex offender training for correctional officers, attorneys, judges, and others appears to be equally essential when working with juvenile sexual behavior problems. It is likely that close collaboration between professionals accounts for significant reductions in recidivism above and beyond any specific treatment interventions. Breaking down the traditional barriers between treatment and corrections is fundamental for optimal treatment of these youth.

Ethics statement: The program evaluation outcome assessment was approved by the county juvenile detention superintendent and chief juvenile judge and presented to the juvenile board for approval. Detention records were reviewed and examined by the director of juvenile detention and the lead juvenile probation officer for accuracy of the data. All data were then de-identified before being analyzed for the current study.

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