

THE

UTAH REPORT

ON

JUVENILE

SEX OFFENDERS

March 1989



The Utah Task Force of the
Utah Network on Juveniles Offending Sexually (NOJOS)

119236

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ACQUISITIONS

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Utah Network on Juveniles Offending Sexually (NOJOS)

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EXECUTIVE SUMMARY

Although Utah has been in the front ranks of states addressing the impact of sexual abuse of children by adults, the extent of the juvenile sex offending problem has not received the same dedicated attention. Focusing attention on the adult offender, while ignoring Utah's escalating juvenile offender numbers, places the burden of intervention strategies and monies at the latter stage of development in the evolution of a sex offender. The cost of this emphasis is increasing numbers of victims.

The Utah Task Force on Juveniles Offending Sexually was created in April 1987 in an effort to identify the extent to which juveniles contribute to the state's child sexual abuse problem. The two major findings of the Task Force are that the number of juveniles referred to juvenile courts for sex offenses is increasing at an alarming rate, and that the majority of these juveniles are not receiving the necessary specialized treatment to prevent their inappropriate behaviors from continuing into adulthood.

The Task Force is advocating that Utah address juvenile sex offender needs by establishing a continuum of legal intervention and treatment services. This continuum includes: definition, investigation, assessment, adjudication, and treatment of the juvenile sex offender.

Varying definitions of juvenile sexual offending behavior have contributed to underreporting of these offenses to proper authorities. In the following report, the Task Force has proposed guidelines to aid in defining juvenile sexual offending behavior. These guidelines include not only recognizing the needs of the general population of juvenile sex offenders, but also those of special populations such as children under 12, developmentally disabled juveniles, and female juveniles.

The Task Force found variation and inconsistencies in the investigation of juvenile sex offenses. As a result, many juveniles are not being referred to the legal system, or if referred are not given legal consequences or adequate treatment for their inappropriate sexual behaviors. In order to adequately assess community risk and dispositional needs of increasing caseloads of juvenile sex offenders, many law enforcement and juvenile court investigators are requesting specialized training.

Juvenile sex offenders require specialized treatment that focuses on their sexual offending behavior. The Task Force found that resources providing the needed specialized treatment are seriously lacking in all geographical areas of the state. The Task Force is advocating that specialized treatment programs be created and funded throughout the state.

To confront the problem of juvenile sexual offending, the Task Force recommends that a Juvenile Sex Offender Act be enacted to allocate funding for developing resources and providing needed training. The Task Force also recommends that guidelines be established for all components of the continuum of legal intervention and treatment services.

1983-1987 Data: Profile of Utah Juvenile Sex Offenders

- * 1707 identified juvenile sex offenders were referred in that 5 year period.
- * There were 258 identified juveniles in 1983 and 399 in 1987 - an increase of 55%.
- * 93% were males.
- * Children 12 years and under represent 16% (277) of the total juvenile sex offenders during the 5 year period.
- * The median age is 14.5 years.
- * In 1987, 70% of total sex offenses by juveniles were felonies.
- * National studies are suggesting that, with treatment, there is a 5-7% recidivism rate. In a Utah study in which over half the sample had no treatment, the recidivism rate was 17%.

Additional Data:

- * In 1988, 78% of all first and second degree felonies against persons by juveniles were sexual in nature.
- * Awareness of the problem of juvenile sexual offending has contributed to significant increases in numbers of identified juvenile sex offenders - e.g. the four county Wasatch Front (Salt Lake, Davis, Weber, Utah) increased in number of offenders from 12 in 1974 to 220 in 1984.

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CHAPTER I

PURPOSE OF REPORT

Since the early 1980's, many professionals in Utah working with juveniles have been advocating the need for specific services for juveniles with sex offenses. On March 20, 1987, Tim Simmons, Director of Court Services of the Fifth District Juvenile Court, presented to the Board of Juvenile Court Directors a proposal for the creation of a state task force which would:

1. Identify current treatment options available for youthful sexual offenders.
2. Identify our state's gaps in services and resources available to work with these children.
3. Work towards filling those gaps in services.

The Directors all agreed the topic was timely and the needs existed on a statewide basis. They approved the proposal, appointed Bryon Matsuda, Chief Probation Officer of the Seventh District Juvenile Court, to head up the effort, and pledged their support. The **Utah Task Force on Juveniles Offending Sexually** was thus created and has met monthly since April 1987.

The multidisciplinary Task Force included membership from all the state agencies involved in the identification and prosecution of juvenile sex offenders such as Juvenile Court, the Division of Youth Corrections, and the Division of Family Services. The team also included community mental health providers from public and private agencies as well as representatives from existing treatment programs from around the state.

The initial purposes of the Task Force were to identify the extent of the problem of juvenile sexual offending and to determine alternatives for dealing with these juveniles. In studying the statistics kept by the Juvenile Court, the Task Force found that the number of juveniles referred to the Juvenile Court for sex related offenses has increased 55% over the past five years. It became clear that there was a very serious incongruence between these rapidly rising numbers of referred sex offenses by juveniles and the alarmingly small resources existing throughout all geographical areas of the state to deal with these juveniles. Police departments and juvenile probation officers were often caught without any options for dealing with increasing caseloads of juvenile sex offenders. Because of the inadequate state resources, many juvenile sex offenders were "falling through the cracks" of appropriate intervention services. This preliminary data suggested that a real crisis of inadequate or entirely absent treatment resources existed in the state.

The serious nature of this crisis is even more evident in viewing juvenile sexual offending as an aspect of the overall problem of child sexual abuse. Many juvenile sex offenders have also been victims of sexual abuse themselves, with some studies reporting that the percentage of juvenile offenders who have been victimized may be as high as 47% (Longo,

1982). Utah, like other parts of the nation, has in recent years experienced a dramatic increase in referrals of sexual offenses against children, perpetrated by adults and youth. Child sexual abuse has become pervasive, affecting persons of all socioeconomic levels, and impacting all areas of our society. Abuse takes its toll in eroding esteem, inflicting grief, and creating a sense of helplessness. Its widespread impact is felt in neighborhoods, schools, and the everyday workforce of America, and is not limited to a few isolated homes. Children's safety has become an issue in all communities as parents struggle to find ways to adequately protect their children.

In awakening to the serious extent of child sexual abuse, Utah enacted legislation which provided innovative programming to address sexual offending by adults. The legislation enacted, which provided both tough penalties and rehabilitative treatment for adult sex offenders, failed to consider the problem of sexual offending by juveniles. Lack of public awareness of the origins of sexually offending behaviors has resulted in this primary emphasis on adult perpetration. Meanwhile, offenses by juveniles go unreported or are minimized or dismissed by supervising adults as simply "curiosity" behavior. Even when offenses by juveniles are brought to the attention of the legal system, there is sometimes reluctance on the part of those investigating to view the sexually offending behavior as criminal or to label the perpetration as sexual offending.

This reluctance to recognize the offensive nature of deviant sexual behavior by juveniles can have tremendous costs to our children, our families, and all of society. Treating adult offenders is more costly and much more difficult than stopping the perpetrating pattern in its early stages. The cost of failing to identify and treat juveniles committing sexually offending behavior is clear in the recent statistics as reported by Abel et al. (1986). They reported that adult sex offenders report an average of 380 total sexual crimes, while adolescents currently being evaluated report an average of less than seven victims. Clearly the cost of failing to provide early intervention is more than monetary; it is also a cost measured physically, emotionally, and spiritually in the lives of children and families.

To effectively address sexual abuse prevention, full public and professional awareness of the importance of identifying and treating JUVENILE perpetrators is essential. Sexual abuse is a behavior which can be extremely harmful to the victim, regardless of the age of the offender who commits the offense. Through correctly identifying juvenile sexually offending behavior as harmful, illegal, and unacceptable, and then interrupting and redirecting that behavior with appropriate therapeutic intervention, many children can be protected from future victimization.

When the Utah Task Force began its work of studying the

problem of juvenile sexual offending in Utah and nationally, they found considerable literature documenting that sexually offending behavior can be compulsive in nature and can escalate into increasingly harmful acts (Carnes, 1983; Lane & Zamora 1984; Ryan et al., 1987). The Task Force therefore acknowledged the need for immediate intervention that interrupts this behavior before it becomes chronic and addictive. Besides their role as identifiers of the problem, the members of the Task Force were also front line workers who continually confront the frustration of providing appropriate treatment for juvenile sex offenders when existing resources are either inadequate or financially inaccessible for the offenders and their families. With the needs of their own client populations in mind, the Task Force mobilized and began addressing the statewide crisis of limited or nonexistent treatment resources.

Recognizing from their own experience as treatment providers that the majority of the juveniles they were treating for referred sex offenses were living in the community and could be treated on an outpatient basis, the Task Force directed their focus to outpatient resources as the greatest immediate need. In choosing to advocate for increased outpatient resources, the Task Force placed high priority on ensuring community safety and hoped to make the best possible use of monies for the greatest number of juveniles.

With this purpose in mind, the Task Force obtained a \$23,000 grant from the Office of Juvenile Justice and Delinquency Prevention to organize and implement a statewide, year long symposium to train professionals from every agency receiving referred juvenile sex offenders. This grant has been used to provide the materials and training staff for the symposium, as well as, recruiting nationally recognized figures in the juvenile sex offender area as consultants. The grant was supplemented by state monies from the Juvenile Court (\$3000), the Division of Youth Corrections (\$2000), and the Division of Family Services (\$2000). The symposium

began in March 1988 with an address given by a nationally recognized speaker, Alison Stickrod, M.S., the founding President of the Oregon Adolescent Sex Offender Treatment Network, and Reporter of the National Task Force on Juvenile Sexual Offending. Response to the symposium invitations was overwhelming, exceeding the limit of 60 slots. The Task Force accepted applications, keeping in mind statewide representation.

Even though the Task Force has moved rapidly in addressing Utah's crisis, a continuum of treatment services is needed to address issues as complex as assessing risk, creating treatment programs, and coordinating among the responsible agencies. Such a continuum of treatment would include outpatient, residential, and secure treatment facilities. Since confusion exists among responsible agencies regarding accountability and the implementation of appropriate programs focused on the juvenile sex offender, a strong need exists for a statewide plan to provide guidelines and direction. The Task Force is therefore recommending that the state plan for dealing with child abuse include a **Juvenile Sex Offender Act**.

It is with the above history and findings that the Utah Task Force for Juveniles Offending Sexually has arrived at this preliminary report. The purpose of this report is to define and identify the specific issues which make up the state's current crisis with juveniles charged with sex offenses. Specifically, this report will cover the following:

- definition of a juvenile sex offender
- a profile of the Utah juvenile sex offender
- guidelines for the establishment of a comprehensive continuum of services
- identification of the gaps in this continuum of services
- recommendations for a statewide plan within the overall problem of child sexual abuse to include a Juvenile Sex Offender Act

CHAPTER II

IDENTIFYING THE PROBLEM

Sexual offenses by juveniles in Utah constitute a serious problem which, until recently, has largely been ignored or minimized. Historically in Utah and nationally, juveniles involved in sexually offending behaviors were not held accountable for the victim impact and criminal nature of their acts. Sexual behaviors which were clearly exploitive and criminal were often dismissed as "adolescent adjustment reactions" or "exploratory experimentation" (Breer, 1987; Ryan, 1986).

As a result of a prevailing attitude of minimizing the responsibility of juvenile sex offenders, there has been a major underreporting of sexual offenses committed by juveniles (Knopp, 1982). Even when sexually aggressive behaviors by juveniles have been brought to the attention of the legal system, intervention by the courts has all too frequently been grossly inadequate, with many cases being dismissed, redefined as non-sexual charges, or plea bargained (Ryan, 1986). Thus, intervention is rarely made at the crucial point where the young offender first exhibits abnormal or abusive sexual behaviors. Not until the behaviors escalate into violent acts of rape, sodomy, or multiple victims does the seriousness of the sexually offending pattern receive notice (California Task Force Report, 1986).

Within the last ten years, a concerted effort has been made by concerned clinicians and researchers throughout the nation to focus attention on the historically ignored problem of juvenile sex offenders. These efforts have been motivated by recent child sexual abuse reports demonstrating that over 50% of the molestation of boys and at least 15-20% of the sexual abuse of girls is perpetrated by adolescents (Rogers & Terry, 1984; Showers, et al., 1983). Statistics and victim surveys indicate that about 20% of all rapes and 30% to 50% of all cases of child sexual abuse can be attributed to adolescent offenders (Brown, et al., 1984; Deisher, et al., 1982). Additionally, approximately 50% of all adult sex offenders report that their first sexual offense occurred during adolescence (Abel, et al., 1985; Becker & Abel, 1985; Gebhard, et al., 1965; Groth, et al., 1982; Smith, 1984). Although this does not mean that 50% of adolescent sex offenders continue committing offenses in adulthood, enough obviously do to warrant serious concern. To prevent multiple victimizations, early clinical intervention is clearly indicated.

Understanding the Juvenile Sex Offender

Juvenile offenders rarely fit the stereotype of an "antisocial child" who is "oversexed" and "on the hunt for victims". Most parents and friends of juvenile sex offenders are surprised when they discover their children's sexual offenses. Awad et al. (1984) compared 24 juvenile delinquents with 24 juvenile sex offenders and discovered a group of sex offenders where "...even the most soul searching parents were unable to recall any signs of a change in their son's behavior in the time

preceding the offense." (p. 114). Among results such as a predominance of middle class status youth among the sex offenders Awad et al. also noted:

It is likely that the present findings with regard to a lesser incidence of truancy, alcohol abuse, and temper tantrums among our (juvenile sex offender) subjects reflects the presence of a subgroup consisting of obedient apparently well-adjusted boys whose sexual difficulties remain unknown to all until the day they commit a sexually deviant act (p. 114).

On the other hand, there is an aggressive subgroup of juvenile sex offenders whose behaviors are easily predictable when their abusive, dysfunctional family background is revealed.

How then are parents and professionals, faced with the diversity of sexual crimes from obscene phone calls to rape and faced with the wide diversity of youth from the class president to the criminally oriented violent youth offender, to understand and subsequently deal with the problem? Margolin (1980) addressed the confusion and misuse of the label "sex offender" when applied to juveniles. She stated that the term is: "...laden with different and changing meanings. The way it is used is as much a function of prejudice and emotion as it is of knowledge and uniform criteria" (p. 7).

Many theories have been proposed on how deviant sexual behaviors begin in juveniles and how those behaviors become established into a pattern. Some of these theories look at environment such as dysfunctional family systems (Lutz & Medway, 1984), or at learning through previous experiences such as modeling theories and prior victimization (Longo, 1982; Steele, 1985). Other theories focus on psychological factors such as a strong sense of helplessness and low self-esteem which lead to an assault cycle (Ryan, et al, 1987), the need for intimacy, or at cognitive distortions and irrational thoughts of the offender (Berenson, 1987).

Many of the premises underlying these theories are based on work with adult offenders and are extrapolated downward to explain similar behaviors in the young. Because juveniles are undergoing an active growing and developing process, juveniles think and respond with a quality that is different, almost naive, when compared to adults making similar decisions or acting out similar behaviors. For example, juveniles are not capable of complete logical thought until the age of 11 to 15 years. (Wadsworth, 1984). Also juveniles are generally not experienced or sophisticated enough to understand such issues of intimacy, negative feelings, and cognitive distortions, and often do not have the appropriate skills to deal with those issues. Consequently, understanding the juvenile sex offender necessitates incorporating the developmental denominator into the overall assessment of each case and creating treatment plans around the developmental concerns of that case.

A typology that approaches this developmental understanding of the juvenile sex offender has been proposed by O'Brien and Bera (1980). Their work has become a classic in the field of juvenile sex offender assessment and many treatment programs and state guidelines have adopted this system of classifying juvenile offenders. The typology includes identifying low risk offenders such as "the naive experimenter" who is generally a first time offender who may have been babysitting and exploited the situation to satisfy an adolescent whim or curiosity. The authors also account for the class president whose family and friends are surprised to learn of his behavior. O'Brien and Bera call this type "the pseudo-socialized child exploiter," and have found such offenders to not have intimacy in their lives, often using rationalizations to exonerate and/or minimize their behaviors. One of the most frequently seen juvenile sex offender types is the "under-socialized child exploiter". These juveniles do not relate well with their peers and often associate with younger children. Many tend to be socially isolated and attempt to achieve intimacy and a sense of self importance through sexually inappropriate behavior. (See Appendix A for complete classification.)

Without advocating specific theories, the Utah Task Force, nonetheless, is strongly supportive of recognizing that juveniles who commit sex offenses need understanding, caring support, and respect for developmental issues just as juveniles who commit other nonsexual delinquent acts. However, despite their age and developmental issues, juvenile sex offenders must still be held accountable for their inappropriate sexual behavior. The Task Force is strongly advocating that such behavior be fully addressed through complete assessment of its extent, appropriate consequences to impress the offender with the seriousness of his/her behavior, and finally with extensive treatment as needed to prevent or intervene on deviant sexual patterns. Though many juveniles may not fully comprehend their behavior and its impact at the time of the offense, they can learn about the impact and how to control impulses and make more appropriate decisions in the future. Because of the qualitative difference between juvenile and adult decision making processes, the prognosis of intervention strategies is more favorable for juveniles than adults. Fay Honey Knopp (1985) has listed the advantages of early intervention with juveniles as follows:

- 1) deviant patterns are less deeply ingrained and are therefore easier to disrupt;
- 2) youth are still experimenting with a variety of patterns of sexual satisfaction which offers alternatives to consistent deviant patterns;
- 3) distorted thinking patterns are less deeply entrenched and can be redirected;
- 4) youth are good candidates for learning new and acceptable social skills;
- 5) public safety is improved by preventing further victimization;
- 6) fiscal economy is enhanced (p.12).

Providing Appropriate Treatment

Traditional mental health methods and incarceration without treatment have both been ineffective in extinguishing sexual offending by adults. The reduction and control of sexually offending behaviors by juveniles therefore requires specialized intervention. Children's needs for specialized treatment programs have fostered the development of juvenile sex offender treatment programs. Although only about 20 such programs were identified nationwide in 1982, a number of factors have since increased the number of these programs to 520 in 1988 (Preliminary Report from the National Task Force on Juvenile Sexual Offending, 1988). These factors include the rapidly increasing numbers of juvenile sex offenders, the demand for treatment resources, the efforts of concerned clinicians throughout the nation in networking and facilitating professional training, and increased public awareness.

The development of specialized programs to assess and treat the juvenile sex offender has frequently been hindered by the lack of available community resources including trained professionals and financial backing. Another major block to the development of juvenile sex offender programs is the necessity of coordinating the various components of such a program among the various agencies and systems involved. The components of reporting, investigation, assessment, treatment, follow-up, and program evaluation are shared among the police, juvenile courts, social services, treatment agencies, and state youth corrections. Historically, there has been significant confusion in the role definitions of various agencies, resulting in inadequacies and/or inconsistencies, creating gaps within the system and restricting the use of community resources.

The national consensus of treatment providers in addressing the above concerns calls for the establishment of a comprehensive service delivery system that provides a continuum of options (National Task Force Report, 1988). Such a continuum would include local community based agencies charged with the identification, assessment and treatment of juvenile sex offenders. Treatment options would necessarily include specialized outpatient treatment, specialized foster care supervision, residential treatment, and secure treatment facilities. Regarding this continuum of services, the National Task Force noted that:

None of the agencies that typically intervene in these cases can effectively control or intervene singlehandedly. Therefore, an interagency approach to sexual assault intervention must take place...Interagency coordination should govern all phases of intervention, from initial disclosure to long-term monitoring of the juvenile offender (p. 11).

The multiple concerns of adequately identifying, appropriately prosecuting, and sufficiently providing assessment and treatment of juvenile sexual offenders is a comprehensive continuum of care that necessitates a multi-team approach. Many states have created a multidisciplinary task force to identify community resources and system deficiencies.

cies. Utah organized such a task force in April, 1987. In less than a year, the work of the Task Force progressed to the function of a statewide network, the **Utah Network on Juveniles Offending Sexually** (NOJOS), that has gone beyond the task of identification of Utah's problem to the task of actively creating and highlighting community resources statewide.

Recidivism: Measuring the Effectiveness of Treatment

With the evidence that adult sexual offending is part of a pattern of behaviors that began in adolescence, (Becker et al., 1986; Longo, 1982), intervention at this initial stage would appear to be prudent both in terms of preventing future victims and disrupting deviant sexual patterns. Experts nationwide working with juvenile offenders have placed great efforts and funds into the belief that sexually offending behavior can be stopped in its early stages. Unfortunately, no controlled studies which evaluate the outcome of treatment have been reported in the literature. Ethical problems rise when juvenile offenders are denied treatment for comparing their subsequent offending behaviors with that of juveniles in treatment.

Nevertheless, in a review of the literature by Davis and Leitenberg (1987), the authors concluded that recidivism data provides "reason for some optimism about the long-term progress for most adolescent sex offenders" (p. 425). For example, a study by Smith and Monastersky (1986) examined the recidivism rate of 223 adolescent sex offenders, most of whom had been in some form of treatment, and found 7% had reoffended over a 20 month follow-up period. Knopp (1982) found a 5% recidivism rate in 80 adolescents who completed a residential treatment program. No mention was made of the extent of the follow-up period.

In a Utah study by Lieker (1986), 154 juveniles who had been convicted of a sex offense between 1974 and 1984 by a juvenile court in the Wasatch Front area were identified for any sexual crimes committed after age 20. Lieker found that 26 or 16.9% of this sample population committed further sex related crimes once they became adults. Of the 154 juveniles, approximately 56% had no treatment. Since the Utah study suggests a recidivism rate double the Smith study (7%) and three times the Knopp study (5%), the question is raised that systematic sex offender specific treatment, if it had been available to all 154 juveniles in the Lieker study, may have decreased the recidivism rate in that sample.

The Intermountain Sexual Abuse Treatment Center in Salt Lake City conducted the only known Utah study comparable to the Smith and Knopp studies by assessing the recidivism rate of juveniles in sex offender specific outpatient treatment. They found a 6% recidivism rate in a one year follow-up of juveniles treated at their agency for the years 1984 through 1986 (A. Brown, personal communication, March 9, 1989).

Much work needs to be done in clarifying the role and effectiveness of treatment in preventing deviant sexual behaviors. Present studies are replete with experimental problems including different criteria for identifying high risk juveniles, for selecting those needing treatment, and for establishing treatment strategies. Also, treatment for juvenile offenders is a recent focus which has not yet allowed for adequate long-term follow-up studies into adulthood. However, the current literature suggests that treated juveniles have lower recidivism rates than adults (Davis & Leitenberg, 1987).

CHAPTER III

DEFINITION OF A JUVENILE SEX OFFENDER

A sex offense involves the use of greater age, force, prestige, intelligence, or other source of power to coerce another person into a sexual act to which they might not otherwise consent (Breer, 1987). Some states have defined the juvenile sex offender as youth at puberty up to the age of majority (Ryan, 1986). However, these definitions are limited in not taking into account sexually inappropriate behaviors perpetrated by children prior to puberty. The commission of sex offenses by prepubescent children is particularly important in Utah in that 16% of juveniles referred to the Juvenile Court for sex offenses between 1983 and 1987 were below the standard age of puberty (13 years).

Knopp (1985) has proposed using criteria suggested by Groth and Loredó (1981) as guidelines for defining the juvenile sex offender. Included in this criteria are the age relationship between the persons involved in the sexual act, the social relationship between the persons involved, the type of sexual activity being exhibited, and elements of coercion used in the offense.

In considering the above definitions of juvenile sex offenders, it is possible to become confused when applying the suggested criteria dogmatically. For example, there may be no age difference between perpetrator and victim, but the act is considered coercive because the victim is not in a position to willingly consent by reason of mental deficiency. Furthermore, an age difference can have different concerns at earlier developmental levels. For example, acts between a 12 year old offender and a 9 year old victim can have a perceptually different impact than a similar act between a 17 year old offender and a 14 year old victim. Therefore, definition criteria cannot be interpreted rigidly.

In blending and integrating the various definitions in the literature, the Utah Task Force proposes the following guidelines for defining a juvenile sex offender:

- A. Any juvenile below the age of 18 as defined in the Utah Criminal Code Annotated who has committed a sexual act as defined by the Utah Criminal Code Annotated (Appendix B).
- B. The act might be defined as a sexual offense if it meets any one of the following criteria:
 1. Power differential
 - a. Age difference - Although the literature has defined age difference anywhere from 3 to 5 years, the Utah Task Force believes that developmental maturity must be taken into account. Thus, age alone is not sufficient in establishing whether a sexual act between two juveniles is considered a sexual offense.
 - b. Larger physical size - Where size is used to intimidate
 - c. Greater mental capacity - Where intelligence or greater developmental maturity is used to gain

- power over another
 - d. Greater physical capacity - Where differences in physical capacity such as handicaps are used to gain power over another
 2. Role differential
 - a. The assumption of authority of one juvenile over another through a leadership role such as babysitting
 3. Predatory patterns
 - a. Any behavior that suggests setting up the victim, such as stalking, preplanning, and/or special treatment of the victim
 4. Elements of coercion
 - a. Any behavior used to secure the victim's trust, to intimidate and/or manipulate the victim to perform an act to which they would not otherwise consent, (i.e. games, tricks, bribes, threat or use of weapons and/or force)
 - C. The sexual act might include any of the following behaviors:
 1. (Listed in order of degree of physical invasiveness to the victim) Fondling, frottage, digital penetration of vagina or anus, oral copulation (fellatio or cunnilingus), object insertion into vagina or anus, penile penetration of vagina or anus (vaginal or anal intercourse)
 2. "Hands-off" offenses (voyeurism, exhibitionism, and/or obscene telephone calls)(Refer to Appendix B for definitions of sex offenses.)

Young Child Sexual Abuse Perpetrator

In establishing guidelines for defining the juvenile sex offender, it is important not to overlook the increasing problem of prepubescent children committing sex offenses. Just as it is necessary to distinguish the characteristics and needs of adolescent offenders from adult offenders, it is equally imperative to recognize and account for the unique considerations of defining, evaluating, and treating prepubescent children who commit sexually abusive behaviors.

Research on adult sex offenders has empirically established that the majority of incarcerated adult sex offenders began committing sexual crimes in early adolescence (Longo & Groth, 1983; Longo & McFaddin, 1981). Programs treating adolescent sex offenders have identified that some of these offenders began their offending patterns of thinking and behavior as early as age 5 (Stickrod & Ryan, 1987). Prior to 1985, the identification and reporting of child offending was almost nonexistent. The National Task Force reported:

Although the literature describing sexually abused children, children in play therapy, and emotionally/behaviorally disturbed children is rampant with accounts of sexu-

ally aggressive behavior, these behaviors have been described as "reactive" or "acting out" and the offending nature has been denied or minimized (p. 42).

In Utah's legal system, juveniles under 8 years old cannot be charged criminally or held liable for the impact of their behavior. The lack of legal sanctions, however, should not deter holding children accountable for sexual behaviors which are clearly coercive, exploitive or aggressive. Such behaviors are legally defined as sexual abuse and are unlawful regardless of the age of the offender (National Task Force Report, 1988; Stickrod & Ryan, 1987).

Since the histories of both juvenile and adult sexual offenders reveal a high incidence of sexual victimization in their childhood (Longo, 1982), it is even more likely that prepubescent offenders have been similarly victimized. Their perpetrating acts may be reflective not only of learned behaviors through modeling, but also, may suggest re-enactment of their own abuse (Stickrod & Ryan, 1987). According to Ryan et al. (1987):

The high incidence of childhood victimization suggests a reactive, conditioned, and/or learned behavior pattern while the progression from early behavior reflects the reinforcing pattern in the development and perpetration of sexually abusive behaviors (p.2).

In recognition of the reactive and progressive nature of sexually abusive behaviors, several groups of clinicians in various parts of the country have developed specialized treatment programs for latency-aged children displaying sexually perpetrating behaviors. Early programs include the "Perpetrator Prevention Program" at Redirecting Sexual Aggression, Inc., a community based program for adolescent and adult offenders in Lakewood, Colorado, and Dr. Toni Cavanaugh-Johnson's work with young child perpetrators at the Child Sexual Abuse Center of Children's Institute International in Los Angeles, California.

Connie Isaac, the executive director of Redirecting Sexual Aggression, Inc. noted that the children in their "Perpetrator Prevention Program" displayed sexually inappropriate behavior that was "progressive, addictive, and chronic", and included calculated preplanning in choosing and grooming a victim and setting up an opportunity structure to offend. She listed the following characteristics of the prepubescent offenders in her program: prior sexual victimization, use of power and control as an exclusive coping response, deficits in social skills, cognitive distortions, low self-esteem, and excessive sexual preoccupation (Isaac, 1987).

Dr. Toni Cavanaugh-Johnson is currently publishing research of a sample of 60 child perpetrators aged 4 to 13 years including 47 males and 13 females. She divided her sample into five groups based on the type of sexual behavior displayed, the age appropriateness of the behavior, the age differential between the participants, and the use of coercion or threats (Cavanaugh-Johnson, 1988). A complete listing of the typology can be found in Appendix C.

The Utah Task Force recognizes that juvenile sex offending is a multifaceted problem that needs to be addressed with respect to the child's stage of development. Current Utah statistics include juveniles ranging from age 4 to 17 years and all of these juveniles, with their diverse developmental needs, must be incorporated into the state's comprehensive continuum of services. Such a diverse range will require the refinement of existing treatment resources to include developmentally specialized resources.

The Developmentally Disabled/Low Functioning Sex Offender

Another group of juvenile sex offenders that has special treatment needs is the population of developmentally disabled or low functioning juveniles. In addition to being identified as developmentally disabled or low functioning, these juveniles are referred to in the literature by several other terms including intellectually handicapped, mentally retarded, learning disabled, or developmentally delayed. As there appears to be no standard term in the literature, the Utah Task Force has chosen to refer to this population by the terms used by the National Task Force, (i.e. developmentally disabled or low functioning).

The term "developmentally disabled" includes "a continuum of mentally disabled persons, from the low functioning client to the seriously retarded" (National Task Force Report, p. 43). In order to focus attention on the more dysfunctional end of this continuum, the Utah Task Force has elected to use the terms developmentally disabled and low functioning in tandem. This discussion will therefore concentrate on those children or adolescents who have been determined to be intellectually handicapped by reason of low IQ, and who meet diagnostic criteria of mild mental retardation, that is, an IQ ranging from 50 to 70 (DSM III-R, 1987).

Clients who are functioning on a borderline intellectual level (IQ range of 70-90) are considered learning disabled and are not the focus of the present discussion. Most juvenile sex offender specialists believe that learning disabled clients can be treated with the general population of juvenile sex offenders, including involvement in sex offender specific peer group therapy, as long as some adjustments are made to account for their cognitive limitations. Such adjustments would include treatment interventions that are concrete in nature rather than abstract, since learning disabled clients tend to be more concrete in their thinking, and have difficulty with formal, abstract thought.

In contrast to the learning disabled, the developmentally disabled / low functioning offenders present a special challenge to the treating clinician. Literature regarding the identifying characteristics and special treatment needs of this population is sparse, and much of what we know concerning these offenders comes from the clinical experience of those who have chosen to specialize in treating the developmentally disabled. The information to be presented in this

discussion is based on what limited information the working committee of the Task Force found in the literature as well as on interviews with clinicians who are directly treating this population.

J. Michael Whitaker, who specializes in residential treatment of the low functioning juvenile sex offender notes that treatment of this population requires a "whole different strategy." Whitaker stresses the importance of a specialized treatment approach in stating:

We cannot be so concerned about rushing in to find solutions for the problem of juvenile sex offending that we overlook that there are different sex offender populations. Treating the low functioning offender must encompass a larger set of issues than standard sex offender specific treatment (personal communication, February 28, 1989).

The developmentally disabled/low functioning population presents several unique differences. In terms of cognitive skills, developmentally disabled/low functioning clients are noticeably more limited than the learning disabled. They lack the ability for abstract thought, and tend to cognitively process information in an overly concrete, experiential manner. According to Whitaker, this makes them overly suggestible and more vulnerable to cognitive distortions and inaccurate perceptions of their environment (personal communication, February 28, 1989).

Other characteristics of the developmentally disabled/low functioning are that they tend to be both more impulsive and more aggressive than the average juvenile sex offender population. Whitaker notes that their impulsiveness may at times have a "primitive" quality, which makes them more vulnerable to violent acting out behaviors (personal communication, February 28, 1989). Parsons (1984) of Ross/Loss & Associates notes:

The majority of adult retarded sex offenders have a long history of exhibiting aggression, manipulation, and control of others through sexual behavior. Their histories usually begin in adolescence as do the histories of adult sex offenders who are not intellectually handicapped (p.1).

Additionally, developmentally disabled/low functioning clients lack the necessary social and adaptive skills to interact positively in interpersonal relationships. Whitaker states:

Treatment with this population must address social deficiencies that do not directly relate to the sexual offending behavior. If these deficiencies are not addressed, treatment will have no long-term effect (personal communication, February 28, 1989).

Because developmentally disabled/low functioning juveniles have the sexual development of an adolescent, but the immature cognitive and emotional functioning of a child, they are "high risk for initiating inappropriate sexual involvements" (National Task Force, p. 43). Also, due to their lack of social and adaptive skills and appropriate sexual training, they are at high risk for sexual victimization. They may be

vulnerable to abuse, either by an older perpetrator or even by a younger perpetrator who is functioning on a higher intellectual level than the developmentally disabled juvenile. The younger participant in the latter sexual encounter may use a coercive style to manipulate an older developmentally disabled juvenile. Being victimized themselves only increases the developmentally disabled juvenile's confusion regarding appropriate sexual messages and sexual expression.

Because of the unique characteristics of the developmentally disabled/low functioning population, specialized treatment is needed. As with any juvenile who commits sexually offending behavior, the developmentally disabled/low functioning offender must be held accountable for the harmful impact of his/her behavior. Parsons (1984) cautions that professionals may tend to minimize sexually offending behavior by the developmentally disabled/low functioning by isolating the incidents of abuse, failing to view the problem in its entirety, failing to hold the retarded offender accountable for his or her behavior, and rationalizing that the courts will probably find the offender incompetent to stand trial on criminal charges. In responding to incidents of sexual offending by the developmentally disabled/low functioning, legal and clinical professionals must consider that:

Whether or not the courts are able to hold an offender who is intellectually handicapped accountable, is and should be a court decision. The fact that sexual abuse involves a crime against victims who are seriously physically or emotionally harmed necessitates that parents or professionals in supervisory roles with the retarded offender must take this problem seriously. They must hold the offender accountable for his/her abusive behavior with the primary goal being that of protecting potential victims from further abuse (Parsons, 1984, p. 1).

Treatment specific to the needs of the developmentally disabled/low functioning offender must of necessity focus on: accountability, behavior management, and development of appropriate social and adaptive skills. Because of the cognitive deficits of this population, with the reliance on concrete operational thought processes, Whitaker recommends that treatment be "experiential" in nature, with use of such techniques as role playing and practicing of desired prosocial behaviors. He further states that such treatment should focus on issues of identity, aggression, self-esteem, information processing, cognitive-affective skill development, social skills development, and sex education (Whitaker, 1988).

Developmentally disabled/low functioning offenders require long-term treatment in a structured environment. Parsons (1984) states:

The retarded offender will need to be under close supervision and involved in an intense confrontive and educational process for a lengthy time period before he even begins to understand that people are now serious about him/her changing or controlling the sexually aggressive behavior (Parsons, 1984, p.3).

Although treatment programs specializing in this population are few in number, those programs that do exist are beginning to report some positive results. Whitaker states that placement in a structured environment such as his residential program for violent low functioning offenders can result in positive intellectual gains. He has noted that although clients in his program initially score intellectually in the mildly mentally retarded range, their deficits in intellectual functioning may be due in part to cultural deprivation. Once in a highly structured environment, many of these offenders display as much as a 15 to 20 point increase in IQ (personal communication, February 28, 1989).

In order to effectively address the needs of the developmentally disabled/low functioning juvenile sex offender, more specialists are needed who are trained in understanding and working with the limitations of this population. Creating additional treatment programs that focus exclusively on the unique needs of this population is essential.

Female Juvenile Offenders

Males represent the majority of sexual offenders in virtually every statistical description studied within the United States. Typical samples suggest that males make up about 95% of the juvenile sex offender population (Fehrenbach et al., 1986; Wasserman & Kappel, 1985). Consistent with these national averages, Utah statistical data indicates that in the 5 year period from 1983 to 1987, 93% of all juveniles referred to the Juvenile Court for sexual offenses were male.

Although females represent only a very small percentage of identified juvenile sex offenders, the actual number of adolescent females perpetrating sexual offenses may well be underreported. Research data by clinicians studying victims of child sexual abuse indicates that approximately 24% of all male victims and 13% of all female victims are victimized by females acting alone or with a male partner (Finkelhor & Russell, 1984; Matthews, 1987). This research did not specify the percentage of child victims who are victimized by adolescent female perpetrators. The National Task Force has noted:

Less is known about female juvenile offenders than any other segment of the sexually offending population, but recent studies on incidence and prevalence of sexual abuse indicate that adolescent females may be responsible for more sexual abuse of children than was previously suspected (p.42).

Several factors may contribute to the failure to identify more females as perpetrators of sexual crimes against children. Just as societal denial inhibits the recognition and acknowledgement that adolescents and even prepubescent children can commit sexually offending behavior, it may also prevent recognition of sexual abuse perpetrated by females (A. Stickrod, personal communication, February 20, 1989). Some researchers have indicated that the incidence of sexual offending by females may be more frequent than is generally recognized because "the socially accepted physical intimacy

between mother and her child may serve to mask incidents of sexual exploitation and abuse on the part of the mother" (Groth, 1982, p.230). The National Task Force states:

Identification and reporting are especially difficult in cases of female perpetrators because of the legitimate authority, easy access, and primary relationships females have to children in our society, as well as the legitimate genital contacts they have with children as a function of child care (p.41).

In identifying adolescents who commit sexual offenses, it may be that a societal double standard prevents accurate identification of female sex offenders, with less condemnation of sexual behavior between a female adolescent and a young boy than between a male adolescent and a young girl (Davis & Leitenberg, 1987).

Most juvenile sex offender treatment programs are designed for the male offender. In general, the motivation of juvenile sex offending by female juvenile offenders does not appear to be significantly different than males (National Task Force Report, 1988). Similar issues would therefore need to be considered in assessment and treatment. Whether the juvenile offender is male or female, treatment should require the offender to demonstrate increased responsibility for his/her sexual behavior, increased understanding of the impact of sexual abuse on victims, increased awareness of his/her emotions and psychological processes that led to the victimizing, and increased understanding of how to meet his/her sexual and social needs without hurting others (Carlson, 1986).

While many of the issues that motivate sexual offending are similar for both genders, clinicians specializing in the treatment of female sex offenders have identified some important differences. Approximately 1/2 to 2/3 of the adult female sex offenders in a Minnesota outpatient treatment program committed sexual abuse in consort with a male - who frequently coerced or pressured them into abusing (Matthews, 1987). This finding is also supported in a previous study of twelve adult female sex offenders referred for outpatient treatment in which half the sample committed their offense in concert with an adult male (Wolfe, 1985). These findings suggest that therapeutic work with female sex offenders must address dependency issues. The National Task Force states:

These triads (cases involving a female perpetrating the abuse with a male perpetrator also involved) require secondary evaluation of the relationship between the two perpetrators as in some cases they are both participating in the perpetration with coercion while in other cases, the female is a passive/compliant participant who is involved in the interaction for entirely unrelated reasons, i.e. dependency on the perpetrator, threats of desertion, etc. (p. 41).

In addition to dependency issues, treatment of female sex offenders must also address the offender's understanding of her own sexuality as well as work through excessive shame. Clinicians working with female sex offenders have observed

that their clients are sometimes fearful of their own sexuality, and often describe their sexuality as learned from males and the inappropriate portrayal of female sexuality by the culture, (e.g. pornography). Female offenders may also be more overwhelmed by the shame of being caught for committing a sexual offense than their male counterparts. This shame may hinder their work on their own identity and growth issues, and in some cases may cause them to become self-destructive. Addressing issues of dependency, sexuality,

and shame therefore becomes very important in the treatment (Matthews, 1987; Matthews, 1988).

A few treatment programs have been recently established to specifically treat the female sex offender. These programs stress the importance of "developing treatment models which incorporate developmental, cultural, and stereotypic sex role issues regarding females" (Matthews, 1987, p.1).

CHAPTER IV

A PROFILE OF UTAH'S JUVENILE SEX OFFENDERS

The data on which this chapter is based was obtained from the Utah State Juvenile Court Information System. Several computer programs were written in order to identify more specifically the extent of Utah's problem with juvenile sex offenders.* Data has been obtained from the years 1983 to 1987 and reflects a 5 year profile of Utah's current juvenile offending population. In addition to this 5 year profile, this chapter refers to data collected by Ala (1986) for the four county area of the Wasatch Front (Salt Lake, Davis, Weber, Utah) from the Juvenile Court Information System for the years 1974 to 1984.

Number of Juvenile Sex Offenders

From 1983 to 1987 the number of juveniles referred to the Juvenile Courts statewide increased from 258 in 1983 to 399 juveniles in 1987 (see Figure 1). This reflects an increase of 55% over the last five years. Anywhere from 12% to 19% of these juveniles for a given year have been reported for multiple sex offenses (see Figure 2). Due to problems in the awareness and identification of juvenile sex offenders as discussed in Chapter 5, these numbers likely reflect a very conservative estimate of the actual numbers of juvenile sex offenders.

Figure 1
Total Number of Sex Offenses by Year

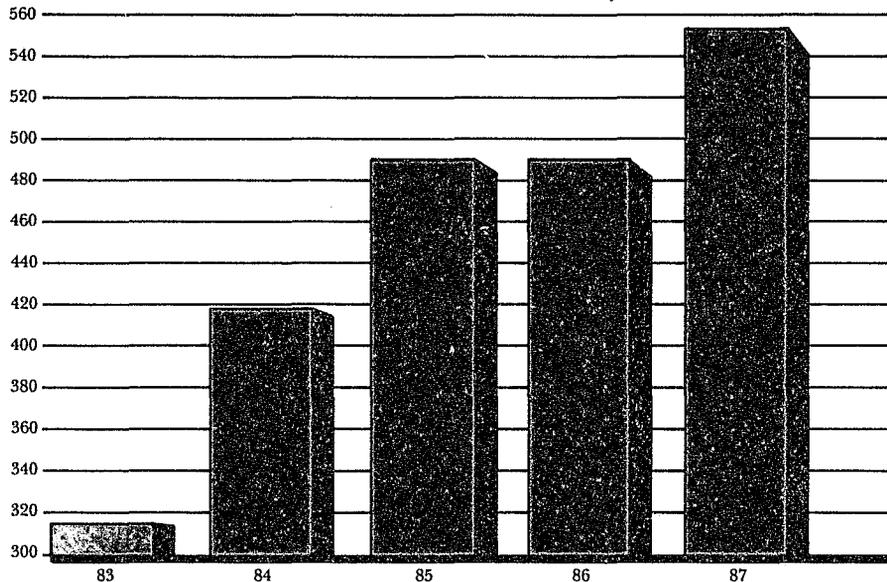
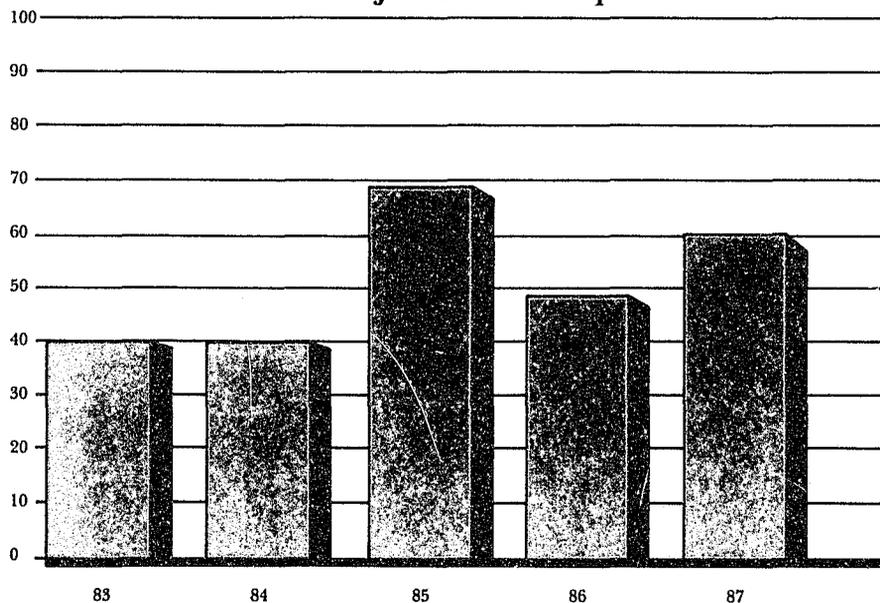


Figure 2
Total Number of Juveniles with Multiple Offenses



*The authors gratefully acknowledge the assistance of Kay Hardy and Don Liether for writing these computer programs.

Gender and Age of Juvenile Sex Offenders

As is consistent with national averages, males represent the overwhelming majority of juvenile sex offenders. Utah's 5 year average is 93% as compared to other state averages of approximately 95% (Michigan Report, 1988; Oregon Report, 1986). Children (12 years and younger) represent 16% (277) of the total juveniles for all five years (1983 to 1987) (see Figures 3-7). Interestingly, although Utah Juvenile Court

does not petition children younger than 8 years old, 12 children were referred to the Juvenile Court from the ages of 4 through 7 years old.

The remaining 84% of the total juvenile sex offenders are adolescents (13 to 17 years) (see Figures 3-7). The median age for total juveniles is 14.5 years, and the first significant rise in number of offenders occurs at age 12 years.

Figure 3
Juvenile Number of Offenders by Age, 1983

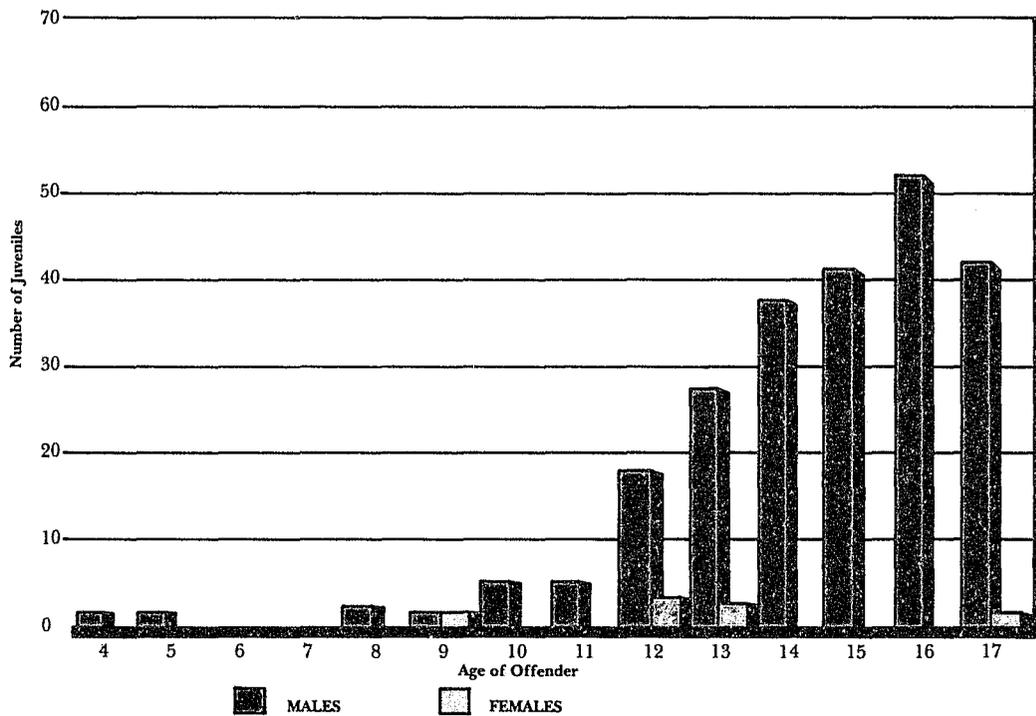


Figure 4
Juvenile Number of Offenders
by Age, 1984

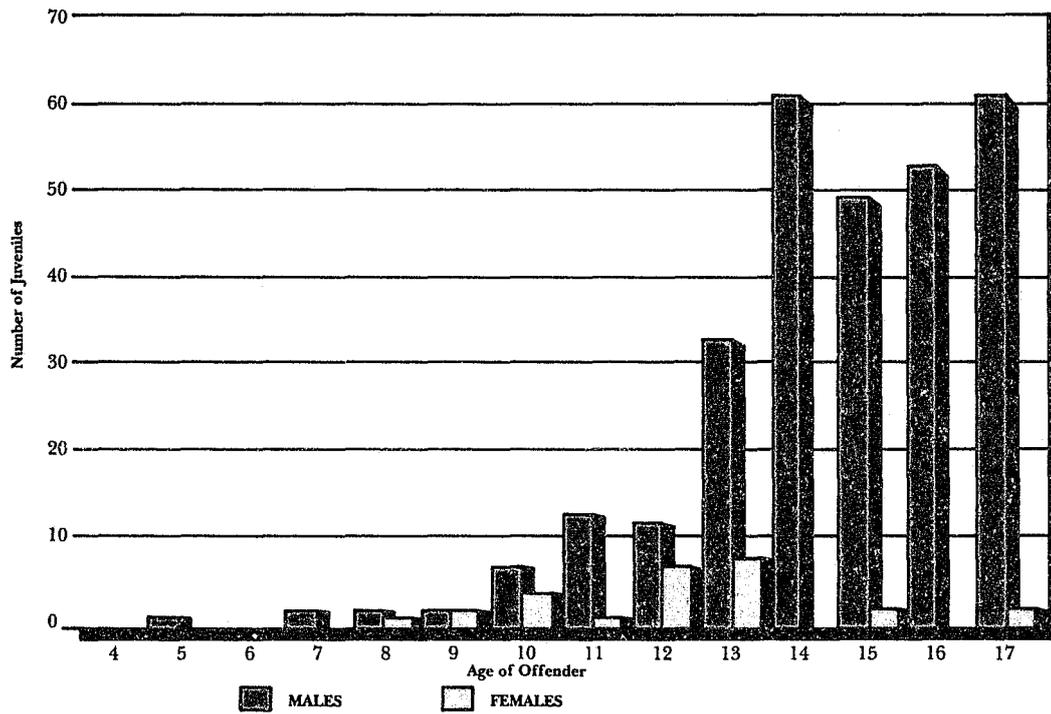
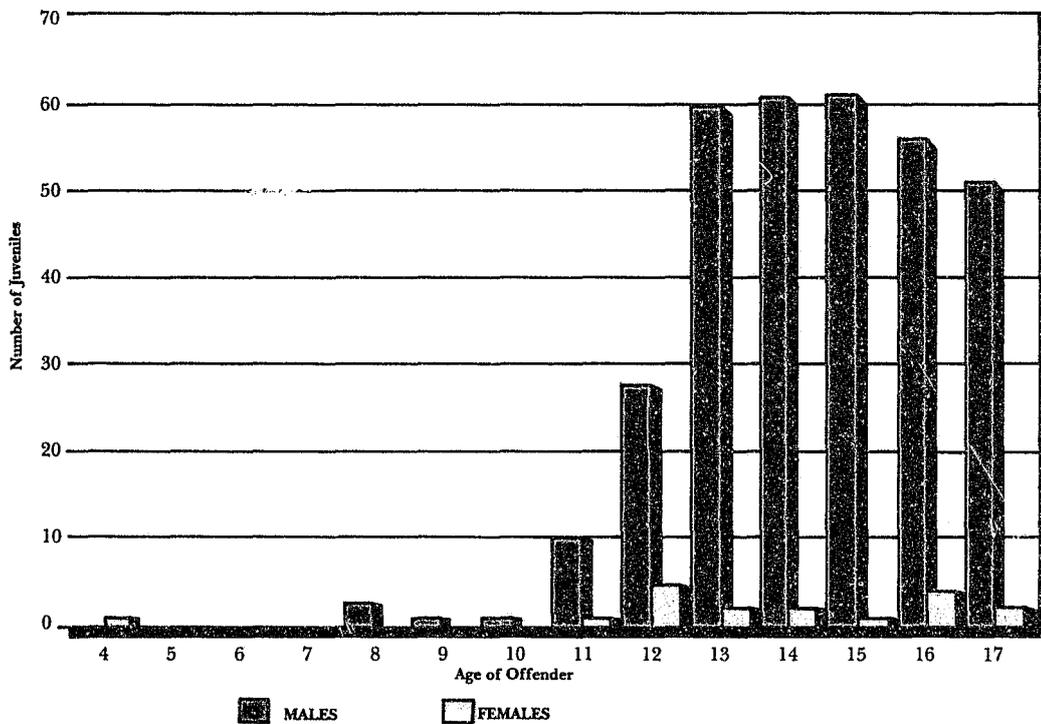


Figure 5
Juvenile Number of Offenders
by Age, 1985



CHAPTER V

INVESTIGATION, ASSESSMENT, AND DISPOSITION OF JUVENILE SEX OFFENDERS IN UTAH

When the research working committee of the Task Force studied the process by which juvenile sex offenders are identified, assessed, and given appropriate consequences and interventions for their criminal behavior, variation and inconsistencies were found in the response of Utah's legal system. Similar inconsistencies have been found in other states (e.g. National Task Force Report, 1988; Oregon Task Force Report, 1986). Cases involving juvenile sexual offenses have been historically underreported, with societal denial dismissing sexually offending behavior by juveniles as "curiosity" or "experimentation." Even when cases are reported to law enforcement or the Division of Family Services, many offenders are not brought to the attention of the Juvenile Court. Cases may be dismissed in the early part of the investigative process because of inadequate understanding by investigators of the clinical seriousness of juvenile sex offenses. Of those cases brought into the legal system, many are given inadequate legal consequences, thus contributing to the minimization of the seriousness of juvenile sexual offending.

The purpose of this chapter is to assist multi-professional and multi-agency teams by clarifying the standard steps in investigating and managing a juvenile sex offender case. This process is represented by the flow chart in Figure 9.

Discovery

Intervention begins whenever a private citizen or professional working with children or adolescents has reason to suspect that an individual has been sexually abused by a person under the age of 18.

Reporting

Utah statute is clear in stating that any person (with exception to the clergy) who "has reason to believe that a child has been abused or neglected.....shall immediately notify the nearest peace officer, law enforcement agency, or office of the division (of Family Services within the state Department of Social Services)" (Utah Code Annotated 1953, Section 3, 78-3b-3). If law enforcement receives the report first, they are required by statute to notify the nearest Office of Community Operations (local unit of the Division of Family Services). In cases where "the initial report of abuse or neglect is made to the division and the abuse or neglect has caused serious injury the division shall immediately notify the local law enforcement agency" (Utah Code Annotated 1953, Section 3, 78-3b-3). As the state agency mandated to provide child protective services, the Division of Family Services through its unit offices (Community Operations) is responsible for facilitating the reporting process.

Criminal Investigation

Both law enforcement and the Office of Community Operations are required by statute to investigate reports of suspected child sexual abuse. The local law enforcement agency who receives the report of suspected sexual abuse is required to initiate an investigation to determine probable cause, (i.e. whether or not a crime has occurred and whether the alleged offender has committed it). The investigative officer is expected to gather evidence to substantiate or refute allegations that a sexual offense has been committed by the juvenile. In determining probable cause, investigators need to be well aware that juvenile sex offenders often deny responsibility for their behavior when initially confronted. A credible victim statement should be considered sufficient probable cause even in the face of perpetrator denial.

In order to make a comprehensive investigation of the alleged offense, it is imperative that both the victim and the perpetrator are interviewed. Cases may be mismanaged when either the investigation is focused exclusively on the perpetrator or the victim only.

In order to most effectively investigate sexual abuse cases perpetrated by juveniles, it is recommended that law enforcement investigators receive specialized training. The National Task Force on Juvenile Sex Offending (1988) suggests that such specialized training include the following:

- dynamics of juvenile sexual aggression
- development of offending behaviors
- victimology and offenderology
- development of sexuality
- assessment of juvenile sexual interactions
- denial systems which support sexual abuse
- child development information relevant to child victims of juvenile offenders
- goals and rationale for early identification and intervention with juveniles
- need for investigation and prosecution
- need for an interagency approach and roles for team members
- didactic and roleplay presentation of specific interviewing techniques for victims and offenders
- validation procedures
- rules for probable cause and evidence
- risk assessment (p. 13).

Number and Type of Sex Offenses

From 1983 to 1987 the number of sex offenses committed by juveniles rose from 314 to 549 offenses statewide (see Figure 1). This reflects an increase of 75% over the last five years. A ten year analysis of a four county sample (the Wasatch Front) (Ala, 1986) indicates the dramatic rise in number of sex offenses from 1974 to 1984 (see Figure 8) attributed to increased public awareness and reporting. The rise in the 5 year profile may represent an increase in actual numbers of offenders as well an increased reporting and awareness.

The data indicates that primarily felony offenses are referred to the Juvenile Court. For example, in 1987, 70% of the total referred juvenile sex offenses were felonies. This data suggests that many "hands-off" sex offenses are not being referred into the court system. Additionally, in 1988, 78% of all crimes against persons committed by juveniles were first or second degree felonies of a sexual nature. This data suggests that sexual crimes among juveniles are a priority concern in the state's Juvenile Court system.

Figure 8

Wasatch Front Juvenile Sex Offenders 1974 - 1984

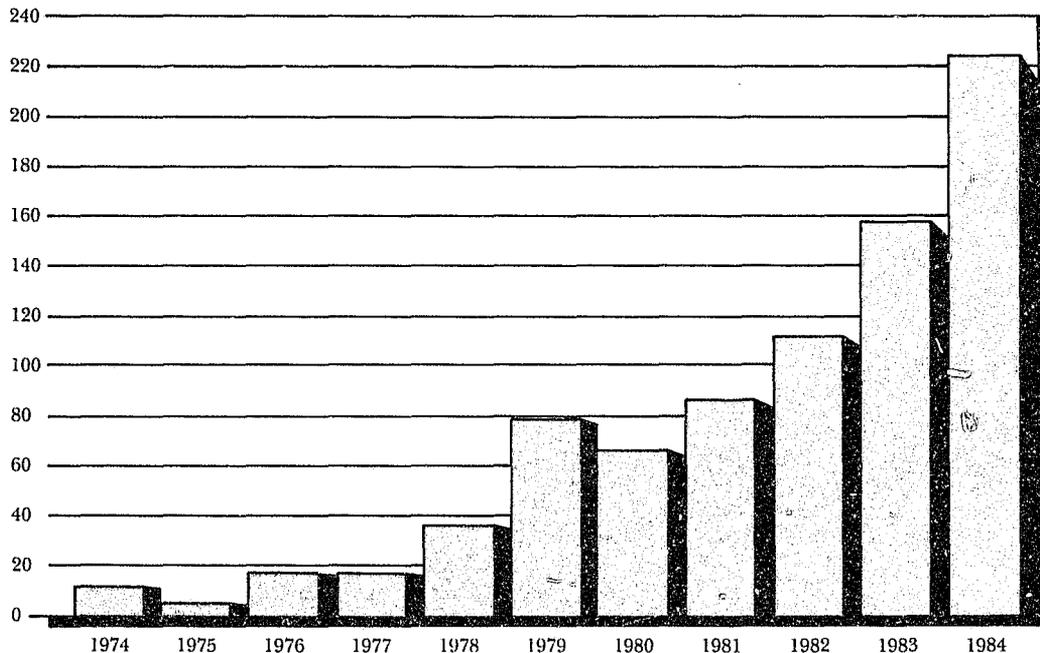


Figure 6

Juvenile Number of Offenders
by Age, 1986

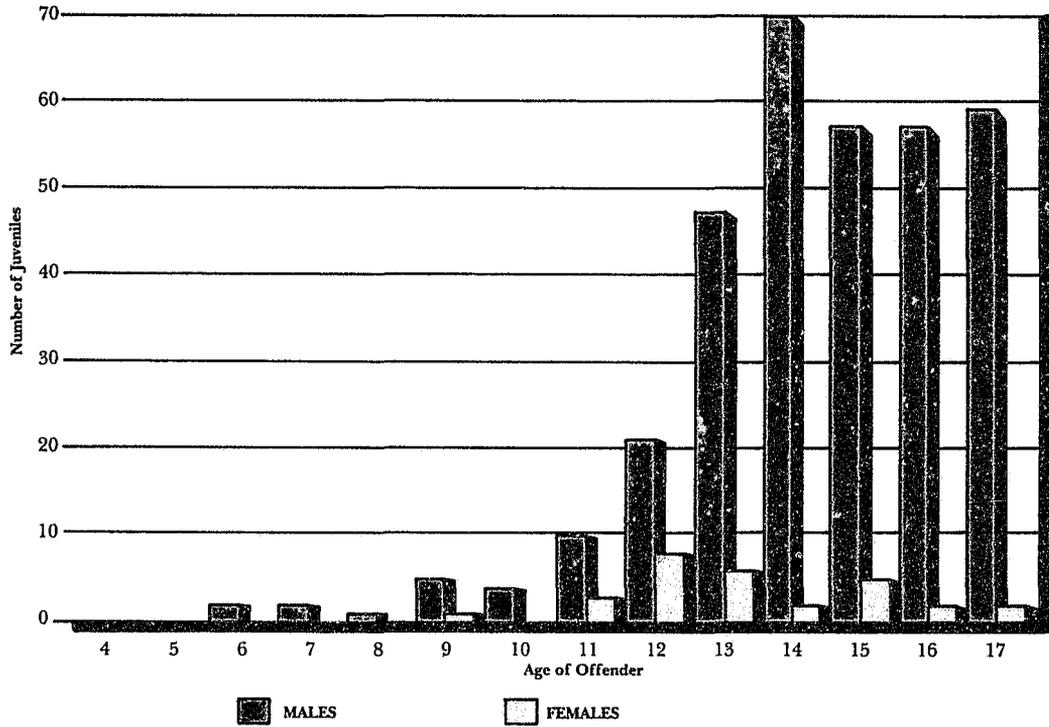


Figure 7

Juvenile Number of Offenders
by Age, 1987

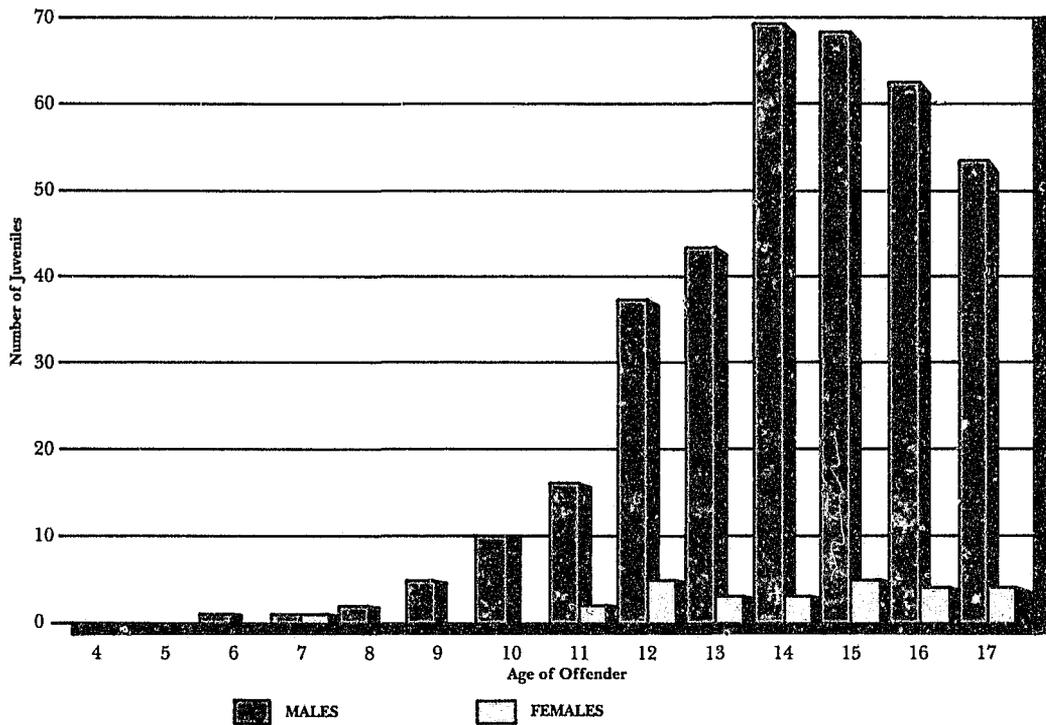
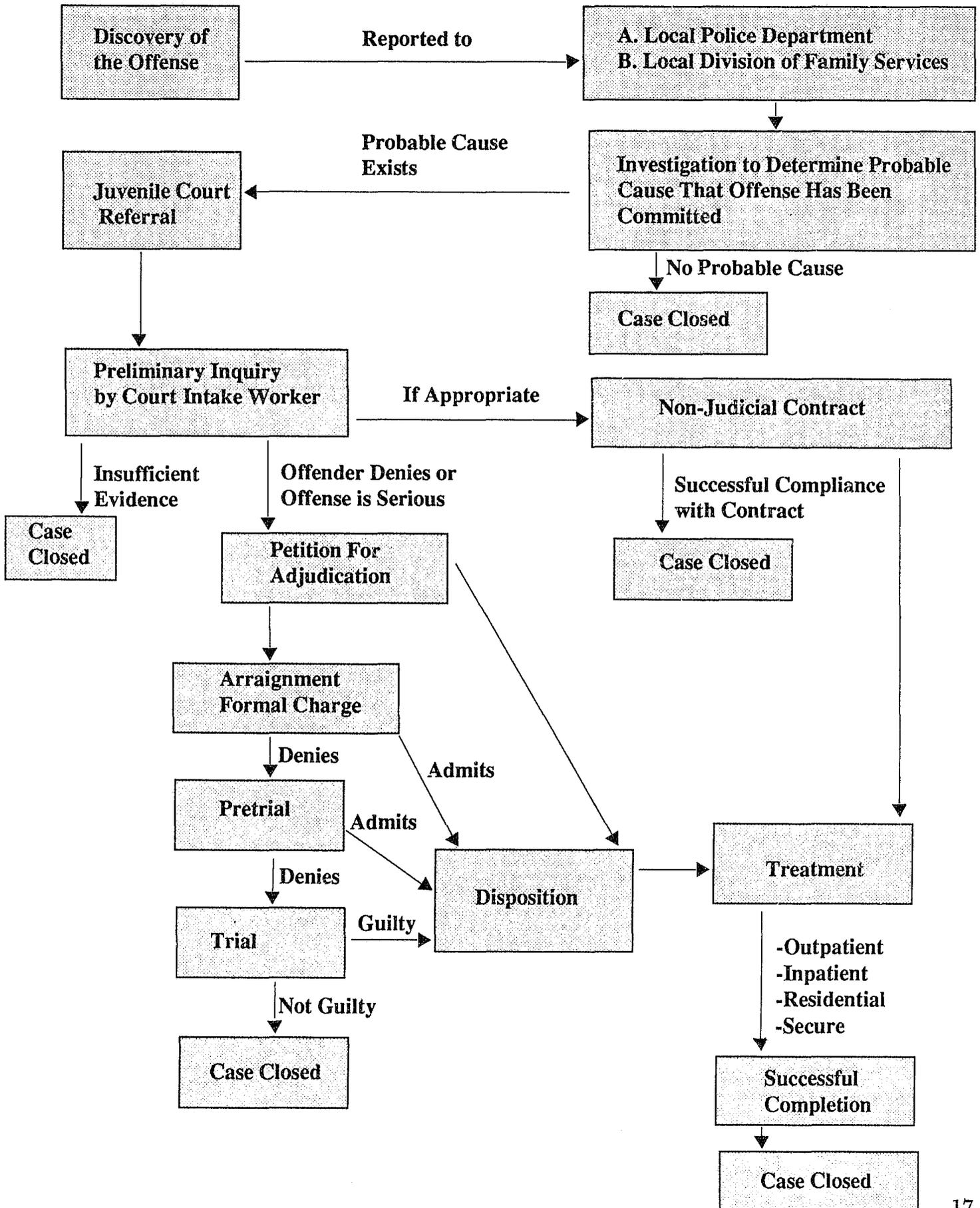


Figure 9
FLOW CHART



Police Report

Upon completing the criminal investigation, the investigative officer must file a written report of the findings with the law enforcement agency conducting the investigation. If the officer finds that there is probable cause to believe that a criminal act has taken place, a copy of the report is forwarded to the Juvenile Court for further handling. If the officer finds that the evidence is insufficient to establish probable cause, the case may be screened with the County Attorney, who determines if the case has prosecutorial merit.

In cases involving first time offenders, "hands-off" offenses (voyeurism, exhibitionism, or obscene telephone calls), or intrafamilial sexual abuse, investigative officers sometimes elect not to refer the juvenile to the Juvenile Court. The officer may defer the investigation to the Office of Community Operations, or encourage the family to seek treatment from local mental health agencies. Such action in these specific cases by investigative officers is problematic, in that it may create a blurring of professional roles, with the investigative function of law enforcement thus taking a dispositional role more appropriately handled by the Juvenile Court.

While first time offenders are less likely to be referred for court intervention, it is important to note that frequently, the first offense identified by criminal investigation is not the first offense that an offender has committed. Clinicians treating juvenile sex offenders have found that offenders, after entering sex offender specialized treatment, often admit to having committed multiple offenses prior to the first adjudicated offense (Lane & Zamora, 1984). The commission of "hands off" offenses must not be minimized by criminal investigators, as research is demonstrating that many adolescent sex offenders had a pattern of such offenses prior to their committing their first sexual offense against another person (Lane & Zamora, 1984; Ryan et al., 1987). Likewise, cases of intrafamilial sexual abuse (sibling incest) should also be considered very seriously by criminal investigators and referred for appropriate court intervention. Recent research comparing sibling incest offenders with child molesters (non-family child victims) and non-child offenders found:

Even though sibling incest offenders are the least likely to be adjudicated of the three comparison groups, they committed more sexual crimes, had more extensive sexual offending careers and were judged to be more severe in their sexual offense histories than either the child molesters or non-child offenders (O'Brien, 1988, p.1).

Legal Intervention

Preliminary Inquiry

The Juvenile Court is responsible for conducting a preliminary inquiry of the alleged offense. An intake officer of the court is assigned to conduct the preliminary inquiry. This officer is responsible for determining the most appropriate legal response to a particular case. The intake officer takes into consideration the crime that has been committed, the response of the alleged offender to the charges, statements of

the victim(s), family history, intellectual, academic, and personality functioning of the offender and the demands for community safety. In order to provide a comprehensive assessment, it is recommended that intake officers be trained in specialized techniques for interviewing juvenile sex offenders. The preliminary inquiry must be completed within 60 days of the referral date. Some jurisdictions, such as the Third District Juvenile Court in Salt Lake County, have a specialized screening team who evaluate all felony sex abuse cases and make recommendations regarding disposition which are included in the completed preliminary inquiry report.

The information collected during the preliminary inquiry should be comprehensive and focus on the specific details of the alleged offender's abusive behavior, the response of the offender to intervention, the amenability of the offender to treatment, and the potential risk of the offender to the community. The Oregon Task Force suggests that the preliminary inquiry should address all of the following:

- the victim's safety
- the offender's level of dangerousness or risk to reoffend
- short-term placement of the offender
- the offender's social and emotional functioning
- the social and age relationship between the persons involved
- how the sexual contact(s) took place
- the persistency of the sexual activity
- the extent to which the exhibited behavior is age appropriate or precocious
- evidence of progression - is the nature or frequency of the sexual activity deteriorating?
- nature of the fantasies that precede or accompany the juvenile's abusive behavior
- distinguishing characteristics of targeted victims
- client's amenability to treatment
- need for a trial to assist in rehabilitation
- "probable cause" for proving a case
- early treatment recommendation (p. 26).

Because of the need for all of the above information in order to make an appropriate disposition, an intake officer will frequently refer an offender for a psychological evaluation, with a request for specific recommendations. Because traditional diagnostic assessments do not provide sufficient data to allow for appropriate placement and intervention decisions (Bengis, 1986), the referral for a psychological evaluation should be made to a therapist who is skilled in the assessment and treatment of juvenile sex offenders. (See Appendix D for a comprehensive list of a complete specialized assessment).

Upon completion of the preliminary inquiry, the intake officer determines whether to petition the case to the court for criminal prosecution (see description of petition process on Page 21). The National Task Force on Juvenile Sex Offending advocates for criminal prosecution of most cases of sexual abuse committed by juveniles, when those cases have legal merit. The National Task Force states:

It is recognized not all reported cases of sexual abuse by juveniles can be prosecuted. Some cases cannot be substantiated with sufficient evidence. Some victims are too young to testify or appear to have insufficient memory of the events by the time a case comes to court; some perpetrators are too young for criminal courts or juvenile courts to hold criminally liable... Although some reported cases are outside the scope of criminal courts, most reported cases with legal merit can and should be prosecuted. (p. 14).

The National Task Force on Juvenile Sex Offending has listed several advantages that accrue from prosecuting juvenile sex offenders. These advantages are as follows:

- prevent further victimization
- protect community
- assure complete investigation of complaint
- demonstrate that offending is serious and will not be tolerated
- hold offender accountable/responsible for behavior
- determine consequences
- support victim's rights and reduce minimization and denial by offender
- evaluate the need for treatment
- facilitate entrance into sexual offender specific treatment and enhance the offender's motivation to change
- assure continued treatment
- provide for supervision and follow-up (order for probation/parole)
- document record of offending (p.14-15)

Since denial of the offense is a characteristic of many juvenile sex offenders when they are initially confronted with their behavior, a statement of denial by the perpetrator does not necessarily indicate that an offense did not take place. According to the National Task Force, "Penetrating denial is a gradual process achieved in treatment and, therefore, the existence of denial should not preclude an offender entering into treatment, . . ." (p. 25).

The intake officer is therefore required to carefully consider any concerns identified in the preliminary inquiry and to strongly encourage the alleged offender and his/her parents to seek appropriate intervention for those concerns. Such recommendations should safeguard the protection of the community while upholding the legal rights of the al-

leged offender and maximizing the opportunity for the juvenile to address and work through denial.

Utah's present statute of limiting the preliminary inquiry investigation to a 60 day time period restricts the ability of the intake officer to address the denial sometimes presented by juvenile sex offenders. In one pioneering project in Lane County, Oregon, intake officers complete an extensive screening of juvenile sex offender cases prior to filing a petition (Stickrod, 1988). Such a screening allows the intake officer flexibility in assisting the alleged offender and his/her parents in understanding layers of fear, shame, and denial, and supports the offender who is in partial admission in taking responsibility for the offense. Alison Stickrod, M.S., an intake officer in Lane County and Reporter of the National Task Force, discusses the merits of Lane County's extensive screening process in stating:

The purpose of intake is to gather the maximum information to recommend the best possible court intervention. Information accuracy is often blocked by offender and family denial. A thorough assessment process respectfully addresses denial by teaching offender and victim awareness and by compassionate confrontation of observed thinking errors. This requires a nontraditional intake interview with expanded interview hours, and blends interviewing and education. It often includes an immediate referral to juvenile sex offender specialized treatment, encouraging client and parent volunteerism.

Where the victim is assured protection, and the offender and his/her family volunteer to immediately enter juvenile sexual offender treatment, the intake officer may expand the intake process to include data from early treatment. This is best applied to low or moderate risk offenders who enter established specialized community based programs that closely coordinate with the Juvenile Court.

In such cases, the preliminary inquiry may be broadly defined to include verification of participation in juvenile sexual offender treatment, further offense description as revealed in treatment, and maintenance of treatment progress. This process enhances intake reporting, creates an opportunity for client and parents to demonstrate volunteerism, fosters client esteem by supporting accountability and truthfulness, and allows a supportive posture from the court (personal communication, February 27, 1989).

Non-judicial closure

In misdemeanor offenses in which offenders readily take responsibility for their behavior and their parents are cooperative with treatment, the intake officer may choose not to prosecute but to manage the cases without court involvement. These non-judicial closures are made with the condition that the offenders and their parents will follow certain specified requirements, which almost always include involvement in outpatient treatment for the sex offense.

A non-judicial closure is initiated with a contract signed by the offender, his/her parents or guardians, and the intake officer. (An example of this contract is found in Appendix E in the "Non-judicial Consent Agreement" used by the Third District Juvenile Court in Salt Lake County). The contract lists the agreed upon conditions, which in addition to extended counseling, may include community service work hours and/or the payment of restitution to the victim for counseling costs. The contract stipulates that if the conditions of the agreement are not completed by a date agreed upon by the offender, his/her parents, and the intake officer, the case may be petitioned to the court for adjudication. The intake officer monitors the offender's compliance to the agreement for an extended time period and closes the case when the conditions of the agreement have been met.

Some inconsistency exists throughout the state Juvenile Court system in the use of non-judicial closures for sex offenses. In Third District Juvenile Court in Salt Lake County, non-judicial closures are limited to misdemeanor cases, since all felony sex offenses are automatically petitioned. In other court jurisdictions of the state, non-judicial closures are used for both misdemeanor and felony sex offenses. Because of this inconsistency, statewide guidelines are needed to provide policies for the use of the more informal intervention of non-judicial closure.

Alison Stickrod cautions against the indiscriminate use of informal disposition (such as Utah's non-judicial closure) and suggests that informal disposition only be used under the following specified criteria:

1. The safety of the victim is assured.
2. The offender is admitting responsibility for the sex offense and is volunteering for treatment.
3. The offender is a low risk for reoffending.
4. The family is highly motivated to participate fully in specialized treatment.
5. Treatment resources are immediately available, and the family verifies that they have contracted for treatment.
6. The system of treatment services in the community where the offender resides is advanced, maximizing offender accountability and monitoring (Stickrod, 1988).

The National Task Force also warns against the use of diversion programs in stating:

Prosecution is generally preferable to nonprosecutorial diversion. This position is taken because offenders view diversion as a reduction in consequences and diversion may contribute to the offender's minimization of the seriousness of the offending behavior (p. 16).

The National Task Force goes on to list criteria for diversion:

Admission of guilt, successful participation and completion of sexual offense-specific treatment, and lack of further delinquent or criminal behaviors should always be

minimum requirements of any diversion for juvenile sexual offenders. . . Diversion should be as closely supervised as probation or parole, with a clear policy to attempt prosecution if the offender does not cooperate (p. 16).

Given these recommendations of the National Task Force, consideration should be given to evaluating the use of non-judicial closures with juvenile sex offenders and establishing statewide guidelines to assist the state's intake officers in determining when non-judicial closures are appropriate.

Closure for Insufficient Evidence

If the alleged offender is denying the charge, the intake officer, after making a thorough investigation and often after consultation with the County Attorney, may determine that there is insufficient evidence to prosecute. The case is then closed and the involvement of the Juvenile Court ceases. If the intake officer in the preliminary inquiry investigation has identified sexual behavior concerns that suggest need for further intervention, but still does not have sufficient evidence to merit prosecution, the officer may recommend to the alleged offender and his/her parents that they consider voluntary treatment.

Special Populations: Sexually Reactive Children Developmentally Disabled/Low Functioning

The special considerations of the populations of sexually reactive children under age 12 and developmentally disabled/low functioning juvenile sex offenders raise other questions as to the appropriateness of prosecution. Children under the age of 12 constituted 16% of the total juveniles referred to the court for sex offenses in the five years from 1983 through 1987 (see Figures 3-7 in Chapter 4). Of these children, 12 were referred to the Juvenile Court from the ages of 4 through 7 years old.

Utah does not presently petition children younger than 8 years old. These children are usually referred to the Office of Community Operations, (unit office of the Division of Family Services), for intervention. In cases involving children between the ages of 8 and 12, who can be petitioned, non-judicial closures are frequently used. It is recommended that such use of non-judicial closures be limited to those children who are a low risk for reoffending, and that cases involving high risk sexually reactive children under age 12 be petitioned. Such action would allow the court to determine the degree of culpability the child has for his/her inappropriate sexual behavior and to more closely monitor placement and treatment.

Cases involving developmentally disabled/low functioning juvenile sex offenders can also be petitioned rather than dealt with non-judicially. As in the case of the sexually reactive child, the court, in the process of adjudication, can determine the degree of culpability that the developmentally disabled/low functioning juvenile has for his/her offense. In court intervention with the developmentally disabled/low

functioning, it is imperative to recognize that despite the offender's intellectual limitations, he/she must still be held accountable for the harmfulness of sexually abusive behavior on others.

Petition

The adjudication process begins with the filing of a petition. The petition is a court document detailing the grounds for jurisdiction in the case. If the County Attorney and the intake officer agree that a petition is justifiable, the petition is written by the intake officer and filed with the clerk of the court. A copy of the petition is then served to the juvenile and his/her parents ensuring at least 48 hours advance notice of the court hearing.

The allegations in the petition must be proved either by an admission of guilt or by the presentation of evidence in a trial. The adjudication process includes up to three separate court proceedings before a Juvenile Court judge. (1) The arraignment, in which the juvenile is formally charged with the criminal charges written in the petition. (2) The pre-trial, in which attempts are made to resolve the case without a trial. (3) The trial, in which formal evidence is presented and the judge then determines the guilt or innocence of the accused. If the offender admits the allegations of the petition at any level of the adjudicatory process, adjudication stops and the case proceeds to disposition.

Disposition

In determining disposition, the court reviews all of the information presented, including the preliminary inquiry, the psychological evaluation, and, if the offender has already entered treatment, reports of treatment progress from the

treating therapist. The recommended treatment plan presented by the intake officer is then approved, revised, or rejected. The court has full authority in determining the placement of the offender and the consequences to be imposed for the offense.

In considering the risk assessment and the treatment plan recommendations, the court determines whether the offender will be placed in outpatient counseling, or will be placed in a residential or secure facility. The court may elect to place the offender on probation and must determine if out of the home placement is indicated. If the offender and his family have already initiated voluntary treatment, it is recommended that the court respect and support this volunteerism, and assist in ensuring treatment success through mandating continued treatment.

In addition to placement and treatment decisions, the court may also impose other restrictions on the offender such as no contact with the victim, prohibition against babysitting, payment of restitution to the victim for counseling costs, and assessment of fines and/or community service work hours. These restrictions can serve a therapeutic purpose in confronting the juvenile sex offender with the consequences of his/her inappropriate behavior and in requiring him/her to make some kind of restitution to the community for the harm he/she has caused to the victim and others affected by the sex offense.

Treatment

The purposes of the case management phases previously described are to provide appropriate identification and legal intervention of the juvenile sex offender, to facilitate rehabilitation, and to ensure the protection and safety of the community. Guidelines for treatment of juvenile sex offenders are described in Chapter 6.

CHAPTER VI

TREATMENT RESOURCES IN UTAH

Therapeutic intervention for juvenile sex offenders requires specialized diagnostic assessment and specialized treatment programs. The Safer Society (Prison Research Education/Action Project) stated in their 1986 review of sex offender programs nationwide that specialization is required for three major reasons:

1. Traditional diagnostic assessments do not provide sufficient data to allow for appropriate placement and intervention decisions.
2. Traditional treatment fails to impact successfully on the non-compliant client who does not voluntarily seek treatment, denies his problems, and is engaged in potentially obsessive, ritualized, and addictive behaviors.
3. Sex offenders may pose a serious risk to the community (Bengis, 1986, p.7).

The National Task Force has defined juvenile sex offender specific treatment as including a peer-based group made up of other juvenile sex offenders. Through experience, most current juvenile sex offender treatment programs have found that comprehensive treatment focuses on group as the central modality with other therapeutic modalities as adjuncts (Knopp, 1982; Oregon Report, 1986). Jonathan Ross, whose Forensic Mental Health Services clinic provides outpatient treatment for adult and juvenile sex offender under a group treatment model, advocates specialized group therapy as the treatment of choice for the majority of adolescent sex offenders. In listing the rationale for group treatment, Ross (1987) states:

The child sexual abuser must learn how to interact with peers in an appropriate manner to satisfy their social needs and help prevent future attraction to relationships with younger children. The aggressive rape offender must learn how to interact with peers and authority figures without abusing power and control. A group therapy setting where the format is more structured and the process closely guided is a powerful form of treatment for those issues (p.3).

The National Task Force has recommended that exceptions to participation in a peer-based group include "only cases where it has been demonstrated the client is unable to function in a group setting because of language barriers, severe psychiatric conditions, or severe intellectual deficits (p.22)." The National Task Force suggests that other treatment components be individualized and lists the following as possible adjunct treatment components:

- individual therapy
- family therapy
- physiological arousal assessment/treatment
- biomedical interventions

- substance abuse intervention
- sex education
- educational assessment for remedial or special
- education referrals
- social skills training
- assertiveness training
- anger management
- victimization issues
- counseling for parental loss issues
- cognitive restructuring
- values clarification
- stress management (p.22).

Because traditional psychotherapeutic techniques of "insight-oriented" therapy have practical and theoretical limitations in extinguishing sexually offending behavior, (Lane & Zamora, 1984; Breer, 1987), most juvenile sex offender specialized treatment programs use cognitive-behavioral and/or psychoeducational therapeutic approaches. Due to the growing recognition that dysfunctional family dynamics may at times either trigger or support sexual offending (National Task Force Report, 1988), many juvenile sex offender programs also apply family systems interventions as an essential component of the treatment.

Cognitive-behavioral approaches require the offender to be accountable for his/her inappropriate sexual behavior and confront the irrational thinking that invariably motivates that behavior. An essential part of many cognitive-behavioral programs is teaching the offender to recognize the "thinking errors" that have allowed him/her to justify his/her abusive behavior towards others (Berenson, 1987).

Another example of a cognitive-behavioral model that requires the juvenile offender to demonstrate understanding of his/her behavior is the "sexual assault cycle." The cycle concept, which was originally formulated in 1978 by Sandra Lane of the Closed Adolescent Treatment Center in Denver, Colorado, has been adapted by a number of clinicians with variations (Lane & Zamora, 1984; Ryan et al., 1987; Stickrod, 1988). From a sexual assault cycle framework, sexually offending behavior results when feelings of helplessness and lack of control in the offender trigger a cycle with identifiable precursors, progressions, and antecedents (National Task Force Report, 1988).

Treatment intervention from a cognitive-behavioral approach requires: (1) offender accountability for his/her abusive behavior; (2) understanding of the sequence of thoughts, feelings, events, circumstances and arousal stimuli

that make up offense antecedents or precursors; (3) application of methods, tools, or procedures learned in therapy to suppress, control, manage, and stop the sexually abusive behavior; and (4) reeducation or resocialization to replace antisocial behaviors with prosocial ones, acquire a more positive self concept, and learn new social and sexual skills to cultivate positive and nonthreatening relationships with others (Knopp, 1985).

The second major treatment approach in juvenile sex offender specialized treatment is the psychoeducational, which most often focuses on sexuality and social development issues. Some of the sexual issues that might be addressed include positive sexual development, sex education, sexual identity, sex role stereotyping, sexual arousal patterns, and sexual fantasies. Social development issues include but are not limited to communication, social skills, assertiveness, and dating and relationship building. Psychoeducational approaches might also focus on other related issues such as identification and management of feelings, stress management, anger management, self-esteem, and values clarification (National Task Force Report, 1988).

Finally, in order to effectively confront the irrational thinking that motivates sexually abusive behavior and require offender accountability for such behavior, treatment programs have come to recognize the importance of including the offender's family in the overall treatment plan. Much like the way family systems are affected by alcoholism or drug abuse, sexual abuse also has deep ill effects, and a family may unknowingly be enabling abuse by ways the family functions. The National Task Force states:

Family systems often share the same dynamics as the offender's and support the offending behavior by their denial and resistance to change. Confused role boundaries, power imbalances, distorted communications, sexual issues, and denial and minimization by family members must be confronted. In some cases, family dysfunction may be a key factor in the development and maintaining of sexually abusive behaviors and family therapy may play an important role in facilitating therapeutic change (p. 34).

Involving the family of the juvenile sex offender in treatment is often crucial to the interruption and extinction of sexually offending behavior. Sexual abuse is often intergenerational (Lutz & Medway, 1984). Clinicians who treat the families of juvenile sex offenders frequently discover that the parents, or other members of previous generations of those families have also experienced sexual victimization. Through effective family systems intervention, families who positively

modify characteristics of dysfunctional interaction effect healthy change in their overall family environment. This directly aids the youthful offender's progress in treatment.

Whether a treatment approach is cognitive-behavioral, psychoeducational, family systems, psychodynamic, or any combination of these or other treatment modalities, effective intervention with juvenile sex offenders requires that issues of victim awareness and prior victimization of the offender be addressed. One of the factors that enables sexually abusive behavior to continue is an underdeveloped sense of empathy toward the victim. In cases where prior victimization exists, treatment of the offender can address the empathy issue by helping the offender to work through feelings associated with his/her own victimization (Ryan et al., 1987). In all cases, techniques that require the offender to see and understand the victim's perspective aid in developing a greater sense of empathy.

In considering the above listed treatment approaches which comprise JUVENILE SEX OFFENDER SPECIFIC TREATMENT, the Utah Task Force strongly supports the National Task Force's recommendations regarding integrating cognitive-behavioral, psychoeducational, and family systems approaches into a comprehensive treatment plan for all offenders. Successful outcome of treatment requires "... drawing on a combination of theories to implement a comprehensive intervention process" (National Task Force Report, p. 31).

The Utah Task Force's working committee completed a preliminary survey of the available treatment resources in the state which provided comprehensive treatment services similar to the above guidelines. Approximately 85 slots are available statewide for sex offender specific outpatient treatment. Additionally, approximately 25 residential and 20 secure inpatient beds are available statewide. Thus, 130 specialized treatment slots are available, which would allow for treatment of only one-third of the total number (399) of referred juvenile sex offenders in 1987.

Less comprehensive treatment services are provided by community resources such as mental health agencies and inpatient hospital programs on a limited basis. These programs, which show an interest in treating juvenile sex offenders, lack many of the essential components as previously listed including the central therapeutic modality of sex offender specific peer group therapy. An additional statewide concern is that many of the clinicians providing juvenile treatment services are clamoring for specialized training in order to deal with their increasing caseloads of juvenile sex offenders.

CHAPTER VII

GAPS IN UTAH'S CONTINUUM OF SERVICES

After a thorough study of the problem of juvenile sex offending in Utah and after comparing Utah's present legal and therapeutic interventions addressing that problem with those in other states, the Utah Task Force has identified the following as areas of concern in Utah's continuum of services:

Reporting

1. Underreporting of sex offenses committed by juveniles due to public misunderstanding and lack of awareness.
2. Variations in the definition of a juvenile sex offender.
3. Differing opinions on how to best serve the needs of the general population of juvenile sex offenders.
4. Differing opinions on how to best serve the needs of specialized populations, i.e. sexually reactive children under 12, developmentally disabled/low functioning juvenile sex offenders, and female juvenile sex offenders.

Investigation

1. Insufficient legal response to referrals of sex offenses by juveniles, due to:
 - a. Reluctance on the part of investigative officers to label sexually offending behavior by juveniles as criminal.
 - b. Placing emphasis on other delinquent acts committed by the juvenile while neglecting to confront the sex offense.
 - c. Inconsistency in applying the penal code defining sexual offenses to juveniles.
 - d. Lack of specialized interviewing techniques by law enforcement officers investigating juvenile sex offenses.
 - e. Failure to thoroughly interview both the juvenile sex offender and the victim.
 - f. Delays in the investigative process in failing to refer juvenile sex offenses to the court in a timely manner.
 - g. Inconsistency in the legal response to juvenile sex offenses in differing law enforcement jurisdictions.
 - h. Lack of statewide guidelines for investigating juvenile sex offenses.

Risk Assessment

1. Lack of a statewide definition of what constitutes risk to the community.
2. Need for specialized techniques to assess the degree of risk posed by the juvenile sex offender to the community.
3. Need for a statewide consensus in formulating and adopting standardized risk assessment instruments.

Adjudication

1. Lack of statewide guidelines in the juvenile court system for assessing and adjudicating juvenile sex offenders.
2. Inconsistency in differing court jurisdictions in the intake procedures for juvenile sex offenders, (i.e. the lack of standardized statewide procedures for conducting a comprehensive preliminary inquiry).
3. Lack of training in specialized interviewing techniques for intake officers investigating juvenile sex offenses.
4. Inconsistency in differing court jurisdictions in criteria for filing petitions and adjudicating juvenile sex offenses.
5. Lack of flexibility in options for adjudication and disposition, (e.g. 60 day time limit for conducting a preliminary inquiry limits options when the offender is denying the offense).
6. Inadequate legal response in some cases through plea bargaining to a lesser offense or a non-sexual offense.
7. Lack of sufficient clinical input in some court jurisdictions in assessing the juvenile sex offender and making recommendations for disposition.
8. Inconsistency in differing court jurisdictions in penalties imposed on the sex offender once the offense has been adjudicated.

Clinical Assessment

1. Lack of standardized guidelines for clinical assessments of juvenile sex offenders.
2. Need for standardized use of comprehensive clinical assessments, as recommended by the National Task Force on Juvenile Sexual Offending, (see Appendix D).
3. Need for additional clinicians with specific expertise in assessing juvenile sex offenders.

Disposition

1. Inconsistency in differing court jurisdictions in the type of treatment ordered by the court.
2. Failure in some cases to sufficiently mandate the participation of the juvenile sex offender and his/her family in treatment.
3. Failure in some cases to require the juvenile sex offender's parents to take financial responsibility for treatment.
4. Inadequate dispositional decisions that refer juvenile sex offenders for traditional psychotherapy and fail to refer to treatment programs that specifically confront the sexually inappropriate behavior.
5. Need for careful monitoring by the court of the progress of juvenile sex offenders in their treatment programs.
6. Need for immediate court consequences for lack of participation or inadequate progress in treatment.

Treatment

1. Insufficient treatment resources providing services along the full range of the continuum from community based outpatient and residential programs to secure facilities.
2. Disparity of treatment resources in different geographical areas of the state, with rural areas severely lacking adequate resources along the full range of the treatment continuum.
3. Inappropriate placement of high risk offenders in community based outpatient programs when residential treatment or placement in a secure facility is needed to ensure community safety.
4. Lack of treatment resources to address the needs of the special populations of sexually reactive children under age 12, developmentally disabled/low functioning juvenile sex offenders, and female juvenile sex offenders.
5. Inadequate therapeutic response to juvenile sex offending through treating the offender with traditional therapeutic techniques rather than specialized techniques that specifically focus on the sexually offending behavior.
6. Need for additional clinicians with expertise in specialized techniques for treating the juvenile sex offender.
7. Need for funding to train clinicians throughout the state in specialized techniques for treating juvenile sex offenders.
8. Failure of treatment programs to employ all needed modalities in treating the juvenile sex offender, (i.e. group, individual, family, and educative components).
9. Failure of some treatment programs to sufficiently involve the juvenile sex offender's family in the treatment.
10. Failure of some treatment providers to report non-participation in treatment or lack of treatment progress to the court.

Aftercare

1. Inadequate discharge planning by some treatment providers.

2. Failure to provide a program of therapeutic aftercare once treatment has been completed.
3. Inadequate supervision of the juvenile sex offender following completion of treatment.

Research and Program Evaluation

1. Insufficient empirically based data in all aspects of the identification, assessment, and treatment of juvenile sex offenders.
2. Lack of data on recidivism rates of juvenile sex offenders who have completed sex offender specific treatment programs.
3. Need for additional research on the specialized populations of sexually reactive prepubescent children, developmentally disabled/low functioning juvenile sex offenders, and female sex offenders.
4. Need for evaluation of programs providing juvenile sex offender specific treatment.
5. Need for funding to support research and the establishment of additional programs that provide juvenile sex offender specific treatment.

Training

1. Need for training additional professionals in all levels of the legal and therapeutic intervention continuum in specialized techniques for identifying, assessing, and treating juvenile sex offenders.
2. Need for provision of this training in all geographical areas of the state.
3. Need for funding to establish and maintain needed training.

CHAPTER VIII

RECOMMENDATIONS

Considering the increased numbers each year of Utah juveniles referred for sex offenses and the critically important need for procedures and resources to deal with those juveniles, the Utah Task Force is recommending the following:

1. That the state of Utah legislate a **Juvenile Sex Offender Act** which would include the following provisions:
 - a. Create an agency in the Office of Criminal and Juvenile Justice and Delinquency Prevention (or similar organization) which would direct the state's need for procedures and resources.
 - b. Legislate funding for that agency which would then funnel specific monies to appropriate juvenile sex offender projects (prevention, education, law enforcement, adjudication, assessment, treatment, research and program evaluation) that would fulfill the state's needs for a comprehensive continuum of services.
 - c. Authorize a permanent voluntary board under the auspices of the created agency to be utilized as a resource to facilitate the creation of guidelines and policies, implementation of training, development and coordination of services, and establishment of treatment programs. This Juvenile Sex Offender Board would be the state's networking branch and would consist of members representing public and private sectors which specifically deal with juvenile sex offenders.
 - d. Authorize monies and guidelines for researching the long-term effectiveness of treatment programs.
2. That the state of Utah formalize a plan establishing a comprehensive continuum of treatment services with emphasis on closing the wide gaps in that continuum in the following areas:
 - a. The provision of specialized training at the investigative level for more accurate screening of cases and judgment of risk assessment.
 - b. The establishment of sex offender specific clinical assessment for all cases referred to the juvenile court in order to facilitate appropriate disposition and placement.
 - c. The development of critically needed community based treatment resources including outpatient services and residential care.
 - d. The development of treatment resources to address the needs of the specialized populations of sexually reactive children under age 12, developmentally disabled/low functioning juvenile sex offenders, and female sex offenders.
3. That the state of Utah establish guidelines delineating the components of a juvenile sex offender specific treatment program. These guidelines, to be addressed by a Juvenile Sex Offender Board, would follow closely the guidelines outlined by the National Task Force. Such guidelines would include group therapy as the primary treatment modality, supported by individual, family, and educational therapy dimensions. Not only would such treatment address the environmental elements and cognitive distortions that lead to inappropriate sexual behaviors, but also, such treatment would address all relevant sexuality issues such as sexual orientation, sex education, sexual history, and specialized techniques for dealing with compulsive and addictive behaviors.

APPENDICES

APPENDIX A

Typology of Adolescent Sexual Offenders

By Michael O'Brien, and Walter Bera, Program for Healthy Adolescent Sexual Expression (PHASE), Maplewood, Minnesota.

Naive Experimenters

1. Tend to be younger adolescents (12-15)
2. No previous history of acting-out problems
3. Adequate social skills/socialization
4. Lack of sexual knowledge and experience
5. Sexual events are isolated, opportunistic, exploratory, situational, non-violent acts with younger children

Under-Socialized Child Exploiters

1. More extensive patterns of sexual behavior with younger children effected through manipulation, enticement, entrapment
2. Chronic social isolation and poor social skills
3. No history of other acting-out behavior
4. Inadequacy, insecurity, low self-worth predominate
5. Family disengaged, father distant

Sexual Aggressives

1. Use of force or violence in commission of sexual assaults against peers, adults, or older children
2. Socially and sexually active with peer group
3. History of antisocial, acting-out behaviors from early childhood
4. Likely to be using alcohol and/or drugs regularly
5. Difficulty handling aggressive impulses
6. Oversensitive to criticism, tense and anxious, emotionally labile
7. Uses primarily denial and projection as defenses
8. Family characterized by chaos, abuse, violence

Sexual Compulsives

1. Engages in repetitive sexually arousing behavior that becomes compulsive, addictive in nature
2. Usually hands-off behaviors such as voyeurism (window peeping), obscene phone calling, exhibitionism, fetish burglary
3. Quiet, socially withdrawn
4. May be studious, tending toward overachievement and perfectionism
5. Constant state of tension and anxiety due to hypersensitivity to failure
6. Inability to express anger appropriately
7. Emotional constraint and anxiety results in tension-reducing acting-out behaviors that involve sexual arousal

8. Behavior becomes patterned, cyclical, and repetitive because it is self-reinforcing
9. Family system rigidly enmeshed with closed external boundaries. Parents may adhere to rigid and fundamentalist religiosity

Disturbed Impulsives

1. Sexual offense is impulsive and signifies acute disturbance
2. Offense may be single, unpredictable, uncharacteristic act or pattern of bizarre and/or ritualistic acts
3. Offenses reflect malfunction of normal inhibitory mechanisms due to thought disorder caused by psychosis either endogenous or drug-induced

Group-Influenced Offenders

1. Sexual offense is an attempt to impress peers, gain approval or acceptance, or prove oneself in peers' presence, e.g., gang rape, "dare" exposing, bathroom abductions
2. Usually no previous history, personality and family characteristics normal

Pseudo-Socialized

1. Active peers—but manipulative relationships, superficial
2. Narcissistic quality—they play on being special, unique; immunity to other people's pain
3. Sociopathic streak
4. Normal on testing
5. Likes to break rules, not get caught, stealing, etc.
6. Seemingly lots of friends, gifted, successful
7. Magnetic, facile in group, plays at social wellness
8. Lack of intimacy—family has high expectations, little closeness
9. Do well in school, high I.Q., computer programmers, hang around adults
10. Love being viewed as precocious
11. Air of superiority
12. Love to do, dream of very adventurous things
13. Lacking intimacy skills, also their fathers lack intimacy skills while appearing very successful.

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APPENDIX B

Utah Criminal Code Annotated Sex Offense Codes

The definitions are taken from the Utah Criminal Code Annotated.

SEXUAL ABUSE OF A CHILD UNDER 14 UCA 76-5-404.1(1). Under circumstances not amounting to rape of a child, object rape of a child, or sodomy upon or an attempt to commit any of these, the actor touches the anus, buttocks or genitalia of a child under 14 or touches the breast of a female child under 14 years of age. SXABC2, Second degree felony.

FORCIBLE SEXUAL ABUSE VICTIM OVER 14 UCA 76-505-404(1). Victim 14 or over under circumstances not amounting to rape, object rape, sodomy or attempted sodomy, the actor touches the anus, buttocks, or any part of the genitals of another, or touches the breast of a female. SXABS2, Second degree felony.

FORCIBLE SEXUAL ABUSE INDECENT LIBERTIES VICTIM OVER 14 UCA 76-05-404(1). Victim 14 or over, takes indecent liberties with another, with intent to cause substantial emotional or bodily pain to any person or with intent to arouse or gratify the sexual desire of any person without consent of the other, regardless of the sex of any participant. SXILB2, Second degree felony.

AGGRAVATED SEXUAL ABUSE, CHILD VICTIM UNDER 14 UCA 76-05-404.1(3). In conjunction with "SXABC2" any of the following circumstances exist; use of weapon, force, duress, violence, intimidation, coercion, menace or threat or harm, or committed during kidnapping, caused bodily injury, severe psychological injury or the accused was a stranger to victim and made friends to commit act. A6SAC1, First degree felony.

SEXUAL ABUSE INDECENT LIBERTIES VICTIM UNDER 14 UCA-76-05-404.1 Under circumstances not amounting to rape of a child, object rape of a child or sodomy upon a child or an attempt to commit any of these, the actor otherwise takes indecent liberties with the actor or another with the intent to arouse or gratify sexual desire. SXIDC2, First degree felony.

SODOMY WITH CONSENT VICTIM 14 OR OVER UCA 76-05-403.1. The actor engages in any sexual act with a person 14 years or older involving the genitals of one person and the mouth or anus of another, regardless of the sex of either participant. SDYMYBH, misdemeanor charge, class B.

SODOMY UPON A CHILD VICTIM UNDER 14 UCA 76-05-403.1. Engaging in any sexual act upon or with a child who is under the age of 14, involving the genitals of the actor or the child and the mouth or anus of either person, regardless of the sex of either participant, SDMY11. First degree felony.

FORCIBLE SODOMY VICTIM OVER 14 UCA 76-05-403.2 Engaging in any sexual act involving the genitals of one person and the mouth or anus of another without the victim's consent and the victim is 14 years of age or older, SDMY21. First degree felony.

RAPE OF A CHILD UNDER 14 YEARS UCA 76-05-402.1 Sexual intercourse with a child who is under the age of 14. RAPCD1, First degree felony.

RAPE OF A CHILD 14 YEARS OR OLDER UCA 76-05-4-2(1.2). Sexual intercourse with another person, not the actor's spouse, without the victim's consent and the victim is 14 or older. RAP21, First degree felony.

OBJECT RAPE - VICTIM 14 YEARS OR OVER 76-05-402.2. Without victim consent, causes the penetration however slight of genital/anal opening of another who is 14 years or older, by any foreign object, substance instrument or device, not including a part of human body, with intent to cause substantial emotional or bodily pain or with intent to arouse/gratify sexual desire of any person. RAPO81, First degree felony.

OBJECT RAPE UPON CHILD UNDER 14 YEARS UCA 76-05-402.3. Causes penetration, however slight, of genital/anal opening of a child under 14 by any foreign object, substance, instrument or device, not including a part of human body with intent to cause substantial emotional or bodily pain to the child or with intent to arouse/gratify the sexual desire of any person. RAPOC1, First degree felony.

LEWDNESS - OBSERVANT UNDER 14 UCA 76-09-702.5(1) Under circumstances not amounting to rape of a child, or attempt to commit any of these, performs an act of sexual intercourse/sodomy, exposes genitals/private parts, masturbates, engages in trespassory voyeurism or performs any other act of gross lewdness in a public place or under circumstances which would likely cause affront/alarm for another 14 or under. ENDCTG - Class B misdemeanor.

LEWDNESS - OBSERVANT 14 YEARS OLD OR OVER UCA 76-09-702(1). Under circumstances not amounting to rape, object rape, forceable sodomy/sexual abuse or an attempt of these, performs an act of sexual intercourse/sodomy, exposes genitals/private parts, masturbates, engages in trespassory voyeurism or performs any other act of gross lewdness in a public place or under circumstances which would likely cause affront/alarm for an other 14 years or under. INDCTH - Class B misdemeanor.

SEXUAL EXPLOITATION OF A MINOR UCA 76-05a-3(1AB). Knowingly produces, distributes or possesses, with intent to distribute, material or a live performance depicting a nude minor (person under 18) for the purpose of sexual arousal of any person or person's engagement in sexual conduct with the minor. SXEPZ Second degree felony.

SEX WITH ONE UNDER 16-3 PLUS YEARS UCA 6-05-401(1,2). Under circumstances not amounting to rape, rape of a child or aggravated sexual assault, a person has sexual intercourse unlawfully with a person not that person's spouse, who is under 16 years of age and is three plus years older than the victim. UNLSX9 Third degree felony.

SEX WITH ONE UNDER 16 - 3 OR LESS YEARS UCA 76-05-401(1,2). Under circumstances not amounting to rape, rape of a child, or aggravated sexual assault, a person has sexual intercourse unlawfully with a person, not that person's spouse, who is under 16 years and the actor is no more than 3 years older than the victim. UNSEXH - Class B misdemeanor.

APPENDIX C
CAVANAUGH-JOHNSON TYPOLOGY

The Utah Task Force suggests the use of the following amended typology for the younger juvenile sex offender as developed by Dr. Toni Cavanaugh-Johnson at the Child Sexual Abuse Center of Children's Institute International (Los Angeles, California)

- I. **Within normal limits:** Children whose sexual behaviors are considered age appropriate and within normal limits (i.e. exploration, curiosity, "playing doctor", same aged, non-coercive).
- II. **Sexually reactive:** Children whose sexual behavior is reactive and non-invasive (i.e. intensified masturbation, precocious sexual interest sexualized behaviors such as "humping", same-aged, non-coercive).
- III **Incipient child perpetrators:** Children who show progression in sexual acting out in minimally invasive sexual behavior (i.e. excessive masturbation, grabbing or touching other children's sexual body parts, same-aged to 3 year difference, coercive).
- IV. **Child perpetrators:** Children whose sexual behaviors are aggressive and coercive (i.e. exposing oneself, fondling, oral sex, penetration of vagina or anus with finger, penis, or objects, age difference of 2 to 10 years, use of force or threats).

APPENDIX D COMPREHENSIVE CLINICAL ASSESSMENT

The Utah Task Force suggests the use of the following list prepared by the National Task Force on Juvenile Sexual Offending as guidelines of issues to consider in completing a comprehensive specialized clinical assessment of a juvenile sex offender: (order does not reflect prioritization)

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

APPENDIX E

Utah State Juvenile Court

THIRD DISTRICT

NON-JUDICIAL CONSENT AGREEMENT

NAME _____ OFFENSE(S) _____

CASE # _____ INCIDENT #(S) _____

Pursuant to having the above entitled matter settled out of Court, I hereby certify that I have been advised and fully understand my right to appear in Court and my right to counsel, and do hereby, of my own free will and choice, waive those rights and acknowledge truth of the offense(s) cited above.

Further, I voluntarily agree to the terms of this consent agreement and will furnish proof to the Court of satisfactory completion of the said agreement on or before the date(s) specified below.

CLOSURE	EXPLANATION	COMPLETION DATE
NJD	_____	_____
NJE	_____	_____
NJS	_____	_____
NJT	_____	_____
NJV	_____	_____
NJW	_____	_____
_____	_____	_____
_____	_____	_____

I understand that failure to complete the above agreement as specified may necessitate an appearance in Court to address the matter.

Dated this _____ day of _____, 19 _____.

Juvenile

As parent/guardian of the above named juvenile, I concur with this Non-judicial Consent Agreement.

Parent/Guardian

Probation Officer

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