TREATMENT EFFICACY OF A JUVENILE SEXUAL OFFENDER TREATMENT PROGRAM

SHEILA M. BYRNE

Treatment Efficacy of a Juvenile Sexual Offender Treatment Program

by

Sheila M. Byrne, B.A., B.Ed.

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Education

Department of Educational Psychology
Faculty of Education
Memorial University of Newfoundland
October 1999

Abstract

This study deals with the efficacy of a juvenile sexual offender treatment program in reducing further offending. The retrospective exploratory research was conducted with 32 juvenile sexual offenders who had been sentenced to secure custody at the Newfoundland and Labrador Youth Centre in Whitbourne. Each of these offenders, while in custody, had completed varying degrees of a treatment program, entitled 'Healthy Lifestyles'. The program was led by facility therapists between April 1994 and October 1997. There were three groups. Group 1 completed the program, group 2 was not offered the program, and group 3 completed the educational component of the program. The study investigated both sexual and nonsexual recidivism of the three groups. It explored factors such as prior convictions, typology, sex of victim, and post release follow-up period. It also investigated a single case of juvenile sexual recidivism. The findings suggested that the educational component of the treatment program was effective in reducing both sexual and nonsexual recidivism. The nonsexual recidivism rate of offenders, who completed the educational component of the program, was much lower than the recidivism rate of the group of juveniles who were not exposed to any of the treatment components. There was a positive correlation between follow-up period and nonsexual recidivism. Juveniles who were not exposed to any of the treatment programs were more likely to re-offend as the follow-up period increased.

Acknowledgements

I would like to thank my husband, Dennis. Without his love, encouragement, and patience, I know this would not have been accomplishable. I would also like to thank my parents who were there to remind me that the end was just around the corner. A special thank you to Dr. Norm Garlie and Mr. Gerry White for their support, encouragement, and direction. I would also like to thank staff members at the Newfoundland and Labrador Youth Centre and the RCMP detachment in Whitbourne for helping me obtain relevant information. Finally, I would like to thank Mrs. Rose O'Reilly for her editing expertise, and Mrs. Fronie Sparkes for her invaluable computer skills.

Table of Contents

List of Tables

List of Figures

Chapter One

Introduction

For years, acts of male adolescent sexual offenders have been dismissed and/or ignored. Often their inappropriate sexual behaviour was considered exploration; that is, normal behaviour of being a boy (Charles and MacDonald, 1997; Coleman, 1997; Shields and Jordan, 1995; Stops and Mays, 1991). Behaviour that was normally deemed inappropriate or illegal when committed by an adult, was condoned in an adolescent purely on the basis of age. Despite society excusing the male adolescent sexual offender, the crimes continue to be committed and people are hurt regardless of the age of the victimizer (Charles and McDonald, 1997; Ryan, 1991).

Since the early 1980's there has been a shift in the consideration given to the adolescent sexual offender. Their 'exploratory' behaviour is now considered a symptom of a much larger problem that must be dealt with through some type of treatment. Therapists and researchers have desperately tried to reveal the importance of not only acknowledging this problem but also of attempting to address it.

Many experts (Barbaree, Hudson and Seto, 1993; Knopp, 1985; Knopp and Lane, 1991) agree that inappropriate sexual behaviours are learned through observation and direct experience. The sexual offender may gain pleasure through this observation and direct experience. As with any behaviour, if pleasure is associated with an act, then that

act may become habitual in an attempt to attain the desired pleasure. This habitual act may then become chronic. Early intervention, before the patterns become chronic, and ingrained in the young person, is extremely important. It is crucial to stop the developmental process of the sexual assault cycle that begins in these adolescent years because it may result in the development of additional deviant sexual interests or abusive patterns (Charles and McDonald, 1997; Knopp, 1985; Stenson and Anderson, 1987). In addition, Charles and McDonald stressed early intervention because adolescent sexual offenders who may have been victimized may be chronologically closer to their own victimization. They believed that a shortened time span may be important in dealing with abuse and should be considered in the treatment process.

It is also important to intervene early in an attempt to arrest such violent acts. Society is affected because every sexually aggressive act adversely affects a person other than the perpetrator. There is an emotional impact on those primarily and secondarily associated with the crime. The hurt does not stop at the victim. Friends and family of both the victim and the perpetrator must also deal with pain and humiliation. The question, of course, is how do we deal with these adolescent perpetrators. It is most important that communities be protected. Incarceration is routine. However, we cannot lock them up and throw away the key. Incarceration without treatment may further jeopardize community safety. What happens when the offender is released? Thirty five to eighty percent of untreated incarcerated sexual offenders commit more sexual crimes upon release (Heinz, Ryan, and Bengis; 1991).

A retrospective study of adult sex offenders, showed that adult sex offenders who began committing sexual crimes as adolescents, will commit 380 sex crimes during their lifetimes (Becker, Kaplan, and Kavoussi, 1988). Studies by Barbaree, Marshall, and Hudson, (1993) found that 20% of rapes and 30-50 % of assaults against children were committed by juveniles. From this we can conclude that a substantial portion of the approximate 380 sexual offenses occur during the adolescent years. These sexual offending juveniles are then more likely to re-offend sexually as adults (Sipe, Jensen and Everett, 1998). Research by, Prentky and Knight (1993), and Hanson and Bussière (1996) confirmed that an early onset of sexual offending positively correlated with the rate of adult sexual recidivism. Specifically, Hanson and Bussière found the strongest predictor of sexual recidivism to be a previous sexual offense. In their study, sex offenders who had committed sex offences in the past sexually re-offended at a rate of 30%. Yet, sex offenders with no previous history of a sexual offence re-offended at a 7% rate.

It is important that we intervene earlier than previously in an attempt to rehabilitate these offenders and curb the progression of a life of sexual crime. This urgency is increased since results from studies indicate that the proportion of adult sexual offenders relative to the total offender population is steadily increasing (Blanchette, 1996). Statistics like these raise fears that there is an increase in the number of juvenile sexual offenses being committed.

There are some studies (Furby, Weinrott and Blackshaw, 1989; Nicholaichuk, 1996; Quinsey, Harris, Rice and Lalumiere, 1993) that conclude that treatment is not effective. Furby et al. (1989) performed a meta-analysis of 425 studies of various adult sexual offender programs and found no evidence that treatment effectively reduces recidivism. This sounds discouraging but as Marshall (1994b) and Hall (1995) point out, Furby et al. analysed studies of treatment programs that were obsolete. Nicholaichuk (1996) compared treated and untreated provincially incarcerated sexual offenders and found low recidivism rates in both groups and no significant differences between the two groups. Nicholaichuk felt that the risk presented by these offenders was not high enough to warrant treatment. Most research, however, has found that treatment is effective in reducing recidivism (Barbaree, 1997; Becker, 1988; Becker and Kaplan, 1993; Hanson, 1996; Lab, Shields and Schondel, 1993; Lombardo, DiGiorgio - Miller 1989).

Fortunately, there is a large amount of literature and research on the adult sexual offender. Therapists have often developed treatment programs for the adolescent sexual offender using these adult programs. Unfortunately, the treatment of choice for treating both adults and adolescents has varied throughout the years and there is still no agreement on what types of treatments work best. Little research has been done regarding adolescent sexual offenders. There is a scarcity of scientifically controlled studies (Shields and Jordon, 1995; Sipe, Jensen, and Everett, 1998). In addition most studies lack a control group and have small sample sizes (Davis and Leitenberg, 1987; Shields and Jordon, 1995). This is especially true of residential programs in open and closed custody

settings (Matthews, 1997). The absence of a control group continues to hinder research (Marshall, Hudson and Ward, 1992). Designing a control group is not an easy task. In fact, it raises some serious ethical questions. How could one justify withholding treatment from offenders for the purposes of research? Would society be adequately protected? (Marshall and Pithers, 1994). Surely there are ethical implications for the offender and future potential victims. Research may support and refine the knowledge and practices that are in existence (Knopp and Lane, 1991).

Statement of Problem

It would be wrong for us to assume that incarceration would automatically eliminate recidivism. We should also not assume that treatment, regardless of its components, would automatically reduce recidivism for sexual offenses. It is important that facilitators deliver programs that target recidivism factors and thereby seek to reduce recidivism.

As previously stated, very few studies have been conducted on juvenile treatment programs and even fewer have been conducted using control groups to establish some type of recidivism data. Therapists must realize that sexual offenders have been sentenced for a specified time by the legal system. After that specified time has lapsed, each of these offenders will be released back into society regardless of perceived success of any treatment. It is essential that open and closed custody facilities maximize the use of their resources to help lower the offender's risk of re-offending, as far as possible, before release. Some measurement of success or failure may help program facilitators determine if treatment efforts are concentrating on the appropriate areas of need and if change to the treatment program is necessary.

The Newfoundland and Labrador Youth Centre (NLYC) in Whitbourne, Newfoundland, Canada, has been providing a locally developed treatment program, entitled 'Healthy Lifestyles' (Reid-White, 1997). It has been offered periodically during the past six years to some of the adolescent sexual offenders in that facility. The NLYC is

the only secure custody facility for juvenile offenders in Newfoundland. Its program consists of the following components: assessment, sex education, disclosure, cycle of abuse, victim empathy, relapse prevention, individual counselling, and community networking. Some adolescent sexual offenders who were sentenced to the facility were not offered the treatment program or did not complete the program because of insufficient resources. Thus, the purpose of this study was to research the recidivism rate of the adolescent sexual offenders who completed the treatment program. The offenders who did not complete the program and those who were not offered the program served as comparison groups. It is the view of the author that the recidivism rate will be an indicator of the effectiveness of the treatment program.

Research Questions

It is my contention that recidivism is a direct measure of the effectiveness of treatment programming aimed at changing offending behaviour. Specific research questions were as follows:

1. Would completion of the Healthy Lifestyles program affect sexual recidivism rate? It was hypothesized that sexual offenders who completed the Healthy Lifestyles program would have a lower sexual recidivism rate than the sexual offenders who did not complete the program.

2. Would completion of the Healthy Lifestyles program affect the nonsexual recidivism rate? It was hypothesized that sexual offenders who completed Healthy Lifestyles would have a lower nonsexual recidivism rate than sexual offenders who did not complete the program.

3. Was there a difference between the rate of sexual recidivism as compared to nonsexual recidivism? It was hypothesized that there would be a lower rate of sexual offense recidivism than nonsexual offense recidivism for both the treated and untreated sexual offenders.

4. Would certain variables correlate with sexual offender recidivism? It was hypothesized that offenders with prior sexual offenses would have a higher rate of sexual recidivism and rapists would have a higher rate of nonsexual recidivism.

5. **Would follow-up period affect recidivism?** Follow-up on each of the offenders was contingent upon their release date and program completion date. It was hypothesized that as the follow-up period increased, so too would the recidivism rate.

Definitions

Canadian Police Information System (CPIC)

The CPIC is Canada's National Police Computer Information System. Persons charged with a Criminal Code offense in Canada and fingerprinted are recorded in a CPIC criminal history (Royal Canadian Mounted Police [RCMP], 1991).

Child Molester

A child molester commits a sexual assault against a child that is at least five years younger than the offender (Barbaree et al., 1993).

Criminal Records Check

This is a check also performed on the CPIC. It provides a list of convictions and discharges on each person listed.

Disposition History

The Disposition History is a printout produced on the YOIS. It gives a list of all of the offenses for which young offenders have been convicted and the sentence for each.

Facility Status History

The Facility Status History is a printout produced on the YOIS. It shows admission and release dates for each offender inquired.

Follow-up Period

The follow-up period is the amount of time that a young offender is tracked. The period started when each young offender was released from closed custody, and ended September 20, 1998.

Hands Off Offenses

Hands off offenses include such offenses as voyeurism, exhibitionism, and obscene phone calls (Ryan, 1991).

Incest Offender

An incest offender is an offender that offends against victims with whom they have a familial or legal relationship (Barbaree et al., 1993).

Juvenile Sexual Offender

The juvenile sexual offender is a legal term that refers to a youth between the ages of 13 and 18 years who engages in sexual behaviour deemed by society to be inappropriate. This is an act (1) against the victim's will (2) without consent, or (3) in an aggressive, exploitative, or threatening manner (Ryan, 1991; Barbaree et al., 1993; Perry and Orchard, 1992).

Multiple Paraphiliacs

Offenders classified as multiple paraphiliacs commit more than one type of sexual deviancy. For example they may commit rape and bestiality (Ryan, 1991).

Persons Check

This is a check performed on the CPIC. It provides the searcher with any immediate pertinent information. It gives the status of the researched individual. For example, it will state whether the offender is on probation, wanted, or currently charged.

Police Profile Sheet

This is a sheet produced after a check on the CPIC. It gives specific information on each particular occurrence in which the police were involved. It provides specific information regarding a case such as the victim's name and age, short description of offense, etc.

Rapist

A rapist is an offender who commits any sexual act that is perpetrated with violence or force which includes oral, anal, or, vaginal penetration (Ryan, 1991).

Recidivism

To recidivate is to relapse into former patterns of behaviour. Relapse may be constituted by: (i) re-conviction and/or re-commission of the same type of sexual offense, re-conviction and/or re-commission of any sex offense; or (ii) re-conviction and/or re-commission of any offense (Furby et al., 1989). In this study, re-conviction and/or re-commission of any sex offense is measured as sexual recidivism, and, re-conviction and/or re-commission of any offense other than a sexual offense is measured as nonsexual recidivism.

Relapse Prevention

Relapse prevention is a self-control program designed to help individuals anticipate and cope with certain behaviour. Relapse prevention is based on the concept that offense precursors can be identified and addressed. It proposes that sex offenses are not impulsive acts but culminated over time (George & Marlatt, 1989).

Sexual Assault

An assault directed at a person's sexual organs, or an assault which, from the circumstances, was clearly sexually motivated. It could subsume everything from a threatened sexual advance or a pinch on the behind to unwanted sexual intercourse unaccompanied by overt threats or the use of a weapon(Committee on Sexual Offences Against Children and Youths, 1984).

Sexual Assault Cycle

The sexual assault cycle integrates situations, thoughts, feelings, and behaviours into a single framework. It is a construct representing cognitive and behavioural progressions occurring prior to, during, and after the sexually abusive behaviour (Lane, 1991).

Young Offender File Number

Each Young Offender is given a unique file number that is used for identification.

Young Offender Information System (YOIS)

The YOIS was developed by the Newfoundland and Labrador Department of Social Services. The system was designed to meet national and federal information needs, to ensure records are kept, and to help the province register and administer services to young offenders (Newfoundland and Labrador Department of Social Services, 1995).

Chapter Two

Review of Literature

Treatment Approaches

There was a change in focus with juvenile sexual offender treatment when studies revealed adult sexual offenders' accounts of their sexual deviancy during their adolescence. Researchers made the connection between these early inappropriate sexual acts during adolescence and the re-offending that occurred later in the individual's life. Researchers looked to adult studies for answers to the juvenile problems. They implemented juvenile treatment programs based on treatment programs being used with adult offenders. Even though there were numerous adult sexual offender programs being offered and revamped there was little awareness, in the juvenile field, of any new developments occurring in the work with adult sex offenders (Knopp and Lane, 1991).

In 1978, Lane developed the 'sexual assault cycle'. Researchers could follow the sexual assault cycle of the offender and determine the precursors of a sexual assault and thus seeks to prevent the occurrence of future offenses. This sexual assault cycle was utilized to provide direction in program conceptualization and implementation.

Still there was very little networking to allow for the exchange of ideas regarding adequate, successful treatment. Therapists did not have any scientifically based theories or models to follow, so most treatments continued to be utilized through 'trial and error'

(Knopp and Lane, 1991). In 1982, Knopp identified 22 programs that offered services to adolescents in the book *Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions.* It listed the program components at that time as typically including family therapy, human sexuality education, victim awareness, social-skills development, anger management, grief, and journal writing. Therapists then used this information as a guide for treatment implementation. Within in the next decade treatment programs flourished but program development varied in the approach used (Kahn and Lafond, 1988). A 1996 Canadian report shows that there were 68 programs treating only juvenile sexual offenders and an additional 56 programs that treated both juvenile and adult sex offenders (Ryerse, 1996).

Generally, program developments focussed on treatment modalities and methodologies that were based on theories about sexual offending. Hall (1996) lists 5 theories upon which treatments appear to have been based. They are as follow:

1. Physiological Model of Sexual Aggression . It posits sexual arousal as the basis of sexually aggressive behaviour.

2. Cognitive Model of Sexual Aggression. It posits that offenders have cognitive distortions that permit him to justify the behaviour.

3. Affective Model of Sexual Aggression. It posits that negative affective states facilitate aggressive acting out and that sexual aggression is a maladaptive attempt to cope with negative affective states.

4. Developmental Model of Sexual Aggression. It posits that sexual

offenders have experienced negative socialization experiences that facilitate sexually aggressive behaviour.

5. The Quadripartite Model of Sexual Aggression. It posits that physiological sexual arousal, cognitive distortions, affective dyscontrol, and developmentally related personality problems are the primary motivational precursors of sexually aggressive behaviour.

In response to theories of sexual abuse, several treatment approaches have been implemented. Hall (1995) suggests behavioural treatments, hormonal treatments and cognitive-behavioural treatments. Other therapists have used sections from each of these treatment approaches and taken what has been referred to as an 'eclectic' approach. The delivery of each of these programs could also occur in different contexts; individual therapy, group therapy, family therapy, or combinations of these.

Behavioural Treatments

Behaviourists posit that sexual arousal to deviant stimuli motivates the male aggressor. Thus, methods that reduce deviant sexual arousal should reduce sexually aggressive behaviour. According to Kahn and Lafond (1988), changing these deviant arousal patterns is basic to successful treatment. Behavioural methods of reducing deviant sexual arousal may include classical conditioning, aversive fantasy, electrical shock, castration, covert sensitization, plethysmographic biofeedback, guided visualization, journals and, masturbatory satiation. As Maletzky (1996) points out, very few treatment programs now follow an approach that is strictly behavioural. This may be attributed to

the treatment's inability to work in all conditions and over a lifetime. It fails to address issues of offender lifestyle and choice. Maletzky also points out that politics, marketing, and practicality have hindered the promotion of behaviour therapy.

Pharmacological Treatments

Bradford (1993), a strong advocate of pharmacology, believes that most of the paraphilias manifested in offenders have their onset in puberty. Such paraphilic behaviour may be reduced through the suppression of the sexual drive. Such treatments involve the use of antiandrogen and hormonal agents, and the use of other pharmacological agents to reduce sexual drive. Advocates of hormonal treatments suggest its use is very effective in suppressing sexual arousal. The antiandrogen hormonal drugs suppress all forms of sexual arousal. Unfortunately they eliminate the sexual outlet for consenting sexual partners. Participation in hormonal treatments is typically voluntary, invasive (intramuscular injections) and lengthy (2 - 5 years). The use of antiandrogens in adolescents is restricted. Antiandrogens can cause fatigue, sleepiness, weight gain, loss of body hair, hepatomas, nausea, vomiting, headaches, leg cramps, hypoglycemia, and depression. Use of such treatment requires close monitoring and managing.

Bradford (1993) suggests that pharmacological agents other than antiandrogens are more acceptable when dealing with adolescents. He cites the problem free use of Mellaril, and the use of Anafranil, clomipramine, and Tegretol but advises that such a treatment approach should be used with caution until its success is empirically supported.

In Hall's meta-analysis (1995) hormonal treatments and cognitive-behavioural

treatments appeared superior to behavioural treatments. Hormonal treatments, however, were not significantly more effective than cognitive-behavioural treatments. Previous studies (Fedoroff, Wisner-Carlson, Dean, and Berlin, 1992; Meyer, Cole and Emory, 1992) sited a practical disadvantage of hormonal treatments. Participants had a refusal rate of one thirds to two thirds and a discontinuing rate of 50%.

Cognitive-Behavioural Approach

Behavioural therapists (Marshall, 1993; Marshall and McKnight, 1975; Marshall and Williams, 1975) expanded their programs to help provide the offenders with skills necessary to deal with appropriate sexual interests. Such approaches became known as cognitive-behavioural treatment. Cognitive-behavioural programs for sexual offenders target deviant sexual arousal, cognitive distortions about sexual aggression, and social skills deficits (Marshall and Barbaree, 1990). Some of the supplements included were sex education, relapse prevention, victim empathy, social skills training, anger management, and addictions counselling (Marshall, 1996).

Most cognitive-behavioural programs delivered some aspect of sex education. Sex education was important because youths lacked knowledge about positive and consensual sexuality. Addressing the youth's cognitive distortion regarding appropriate sexual behaviour was very important. Programs that followed this educational model focussed on self-esteem, social skills, and family and individual therapy. For example, Lakey (1994) felt that juvenile offenders lacked the knowledge gained in a suitable sex education program. For these juveniles, treatment of any cognitive distortions and

'thinking errors' was essential and should be addressed in group therapy. Lakey also felt empathy for the victim was an important element in treatment as it placed the offender in touch with any trauma caused to the victim. To DiGiorgio-Miller (1994), empathy was the most powerful reason not to re-offend.

Laws (1988) and Marshall (1996) felt that, since its inception in the 1980's, relapse prevention, as an adjunct to cognitive behavioural therapy, was emerging as a major sex offender treatment. The relapse prevention model of addiction was modified for use with sex offenders by Pithers and Gray in 1983 (Pithers and Gray, 1996). It is a theoretical construct that suggests that sexual offenders cannot be 'cured' but can be given the skills necessary to recognize and deal with precursors to sexual offending.

Becker et al. (1988) studied the use of relapse prevention in the treatment of juvenile sexual offenders at the Sexual Behaviour Clinic of the New York State Psychiatric Institute. These juveniles were offered a cognitive behavioural treatment program which consisted of verbal satiation, cognitive restructuring, covert sensitization, social skills training, sex education, values clarification, and relapse prevention. The study found that the program was effective in reducing inappropriate sexual arousal in adolescent offenders who were involved with male victims. In 1990, Becker studied another cognitive behavioural model that included relapse prevention. It, too, showed treatment to be effective with adolescents. Again in 1993, Becker and Kaplan reported that the most popular and widely recognized therapy for adolescents (cognitive behavioural with relapse prevention) was effective in treating adolescents.

Eclectic Approach

Many therapists utilize components of the various treatment approaches in an effort to offer a program that they feel best suits the need of the offenders. Stenson and Anderson (1987) suggested that adolescent sexual offender treatment be in accordance with assessed individual needs and that therapy should focus on the family unit. Kahn and Lafond (1988) recommended a multifaceted program that focussed to change the offender's emotions, cognition and behaviours. Borduin, Hennggeler, Blaske, and Stein (1990) supported a multi-systemic approach that addresses the offender and the systems that influence their behaviour such as family, peers and school. Lab et al. (1993) found that psycho-social educational therapy, with an eclectic approach that addressed social skills, education, and values was, an effective treatment.

Future Directions

Varying approaches have resulted in a lack of agreement regarding the most effective interventions for adolescent sexual offenders might be (Coleman, 1997). This is coupled with the fact that not enough is known about the adolescent sexual offender population to be able to definitely state that there is one ideal form of intervention (Charles and McDonald, 1997). Ways of evaluating/measuring the effectiveness of any of these treatments are scarce. The literature has, however, led the author to believe that there is some merit in a cognitive-behavioural program that has relapse therapy as an adjunct. For years, adolescent sexual offender programs have followed the adult sexual offender program trends. Since its introduction in 1983, relapse prevention has steadily increased

in its popularity. In Hanson's (1996) review of adult programs it was found that almost all Canadian sexual offender treatment programs included relapse prevention. Matthews (1997) listed several treatment approaches that he believed to be examples of the best practice for adolescent sexual offenders in Canada. Relapse prevention is on the list.

In the early 1980's the recidivism rate of treated offenders was unacceptably high. Relapse prevention validated the theory that the risk of re-offending was an ongoing issue for each offender. Relapse prevention identified recidivism as an expected but workable problem (Hanson 1996).

Becker and her colleagues have been the forerunners in developing treatment approaches specifically for juvenile sex offenders (Marshall, 1996). They have been using the cognitive-behavioural approach in conjunction with relapse prevention therapy since the late 1980's and have results that support its effectiveness. Gray and Pithers (1993) also supported the use of relapse prevention not only with sexually aggressive adolescents but also with sexually aggressive children. For them, relapse prevention served three distinct functions in sexual offender treatment. First, relapse prevention helped the sexual offender develop an awareness of the choices affecting their behaviour, and helped develop coping skills, victim empathy and self-control. Second, it fostered the development of collaborative relationships between helping professionals and individuals, and increased the monitoring of the offenders' behaviours. Third, it permitted the integration of treatment approaches into a single comprehensive therapeutic framework.

Treatment Considerations

Juvenile sexual offenders have a diversity of needs which treatment programs have tried to address. Specifically defining the treatment modalities which compose a program is not an easy task (Knopp and Lane,1991). Not enough is known about the offender to be able to state that there is one ideal form of intervention. Regardless of the treatment modalities implemented, programs should address similar treatment issues. It is important that a program respond to and compliment the skills and needs of the adolescent sex offender. Perry and Orchard (1992) list the following considerations as important when structuring treatment.

1. Helping adolescents to assume responsibility for their offenses by challenging the rationalizations, denials and minimizations upon which offenders rely to avoid assuming responsibility.

2. Helping adolescent sex offenders to develop empathy for the experience of their victims and a more comprehensive emotional awareness in all aspects of their lives.

3. Assisting offenders in achieving a more complete understanding of their own individual offense pattern, and working with them to develop strategies to use if they find themselves once again beginning the cycle leading to offending behaviour.

4. Providing new information to challenge their very rigid, stereotyped ideas about sex roles and intimacy, and their misinformation about sexuality.

5. Providing various skill training elements, including assertiveness and anger management, to remediate deficits that impede successful functioning (p.65).

Similarly, Williams (1996) suggested that sex offender treatment programs in Canada "motivate the offender to take responsibility for the offense, help them identify their crime cycle, teach them to deal with deviant sexual fantasies and urges, and help them learn to cope with barriers to meaningful consensual and age appropriate relationships" (p.33). Williams went on to say that some issues can be dealt with cognitively but a behavioural component may be necessary. Furthermore, Williams supported the use of group and/or individual therapy. Williams also listed the treatment goals for the provision of services to sex offenders as follows: recognition and acceptance of criminal behaviour; awareness and replacement of the processes which underlie sexual behaviour; improvement of social skills through empathy and anger management; development of healthy sexual lifestyles; understanding offender as victim; and, awareness and development of relapse prevention. Many others suggested combinations of the aforementioned (Bentovim, 1991; Charles and McDonald, 1997; Matthews, 1997; Stenson and Anderson, 1987; Thomas, 1991).

Recidivism

There is no established way to measure recidivism. It depends upon the question(s) that are asked. Researchers have used the official measure of additional sexual criminal convictions and various unofficial measures such as: charges but not convictions; convictions of nonsexual offenses; re-admissions to custody; self reports; and informal reports from agencies such as police and Children's Aid Societies (Hall, 1995; Hanson and Bussière, 1996). For example, Furby et al. (1989), while conducting their meta-analysis, discovered that many researchers had used different standards to measure recidivism. In order to proceed they were forced to determine a standard of measurement that could apply to all studies included in their meta-analysis. Furby et al. believed it was necessary to include all re-offences committed by the offender when determining the number of sex offenders who continue to commit crimes. They did not limit their study to sexual re-offences. They argued that the inclusion of all re-offenses was beneficial because a treatment's effectiveness in reducing any further criminal activity was thus measured and that it may have been only chance that the sexual offender was caught first for committing a nonsexual crime if he was committing both at the same time. Hall (1995) took a different approach. He limited the scope of his study to only additionally sexually aggressive behaviour which resulted in additional official legal charges. In this study, I will use two definitions of recidivism (i) additional sexually aggressive behaviour which results in a sexual conviction, categorized as sexual recidivism, and (ii) conviction for a subsequent nonsexual offense, categorized as nonsexual recidivism. These additional

offenses must occur in the follow-up period. Measures of both sexual recidivism and nonsexual recidivism will assist in determining the effectiveness of the treatment program in curbing any further offending.

After determining the measure for establishing recidivism there is a need to specify the length of time that an offender will be followed for detection of further crimes. This is referred to as a follow-up period. The follow-up period specifies the amount of time during which commission of an act will constitute relapse and thus recidivism. Follow-up can start immediately following the completion of a program designed to prevent recidivism or sometime after. It may begin while the offender is in custody or upon release. If the follow-up period starts upon release from institutional confinement then it represents actual time at risk in the community. Most sexual offenders would be expected to have low rates of sexual recidivism in the first few years of follow-up (Hanson, 1997). This is simply because a short follow-up period translates into less time to commit the crime, get caught, and get processed through the courts. Hence, the longer the follow-up period the greater the likelihood that offenders will re-offend because they have had more opportunity chronologically to re-offend. Also, the longer the passage of time, the less powerful the treatment effect (Barbaree, 1997; Cooper, 1994; Fisher, 1994; Gibbens, Soothill and Way, 1981; Hanson and Harris, 1998; Marshall and Barbaree, 1988; Williams, 1996;). For example, Hanson, Steffy, and Gauthier's study (1992) of adult child molesters found the greatest risk of re-offending to occur between the fifth and tenth years. For the purposes of the present study, follow-up dated back to each offender's

release from closed custody and continued until September 20, 1998.

Recidivism Correlates

There are many variables that correlate with recidivism. Therapists assess offenders and determine these variables in an attempt to predict the probability of recidivism (Hall and Hirschman, 1991). These variables can be divided into four categories; criminal history, current offense, personal characteristics, and treatment (Proulx, Granger, Ouiment, McKibben, Perreault, and St-Yves, 1996).

Criminal history may include such factors as previous sexual and nonsexual offenses and any other incidents of legal involvement. One of the most consistent predictors of sexual recidivism is a history of prior sexual offense convictions (Hall, 1988; Hanson, Steffy, & Gauthier, 1992; Marshall & Barbaree, 1988;). In the present study, all incidents of legal involvement for which there was a conviction were included and will be further discussed in Chapter III.

Current offense factors include fixed factors such as age and gender of the victims, age of the offender, relation to the victim, and description and details of the offence. This information pertaining to current offenses can be used in developing a typology of the sexual offender. Typologies have been developed through numerous taxonomic systems for adult male sexual offenders (Becker, Harris, and Sales, 1993). For example, Knight and Prentky (1991) developed two taxonomic systems. One classified child molesters, the other classified rapists. Motiuk and Brown (1996) classified sexual offenders into three groups; incest offender, paedophile, or rapist. Juvenile sexual offenders were categorized

by Smith and Monastersky (1986). They categorized juvenile sexual offenders based on three types of offenses; rape, indecent liberties, and hands off offenses. Ryan (1991) categorized juveniles based on rape, molestation, hands-off, and multiple paraphiliacs. Regardless of the categorization, it is important to remember that adolescent sexual offenders are not a homogeneous group. It is anticipated that the recidivism rates of juvenile sexual offenders will be affected by the juveniles' presenting sexual offenses. Therefore it is necessary to use some method of categorization contingent upon the sexual offenses committed (Sipe, Jensen, and Everett, 1998). For the present study, offenders will be classified into one of six categories: incest offender, child molester, rapist, multiple paraphiliacs, or other. These were previously described in the definition section of the Introduction.

The personal characteristics of the offender should be considered if available. For example, the offender's sexual preference, employment status, place of residence, drug and alcohol use, mood, social skills, education, family background and dynamics, and victim empathy are some of the essential factors that may be considered when developing a treatment program to suit individual needs. (Kahn and Lafond, 1988; Charles and McDonald, 1997; Shields and Jordan, 1995; Hanson and Harris, 1998). To address the individual needs of the offenders in the present study, drug and alcohol use, social skills, education, family background and dynamics, and victim empathy were considered by the facilitators when implementing the program.

As previously discussed, treatment for adolescent sexual offenders varies. Most

treatments are designed to address the variables surrounding each sexual offense and the juveniles' personal characteristics. The effectiveness of these treatments in addressing these variables ultimately affects recidivism. Unfortunately, difficulty arises as the availability of the number of victims, type of sexual offense, and characteristics of sexual offenders is insufficient (Motiuk and Brown, 1996). Thus, some treatment programs may not be suitable simply because of insufficient information to permit matching treatment to individual needs.

Adult Recidivism

Recidivism research on the effectiveness of current adolescent sexual offender treatment is scarce and inconsistent (Kahn et at., 1991; Lakey, 1994). Much of the data is based on the adult offender. The Pithers, Kashima, Cumming, Beal, and Buell (1988) study of a treatment program offered to adult sexual offenders in the Vermont Treatment Program, found a recidivism rate for sexual offenses of 4%. In his long term follow-up of adult child molesters, Hanson (1992) determined that offenders who selected male victims were more likely to be re-convicted and that there was no significant difference in recidivism between the treatment groups and the two control groups. In 1995, Hall found a recidivism rate of 19% for treated sexual offenders and a rate of 27% for untreated sexual offenders. Motiuk and Brown (1996) found 10% of their sample were re-convicted of a new sexual offense in a 3½ year follow-up period. Thirty three percent were re-convicted of a new nonsexual offence. They also found higher rates of nonsexual re-offending among paedophiles. Hanson and Bussière (1996) found differences in adult

recidivism based on the age and sex of the victims. In their study, sex offenders who victimized boys or adult females were more likely to recidivate than those who victimized related girls. Quinsey (1996) found the number of previous sex offences and extrafamilial male victim offenders positively correlated with recidivism rate. Nicholaichuk (1996) found federally and provincially incarcerated sex offenders who completed relapse prevention treatment programs recidivated less than offenders who received no treatment. In a study of adult rapists and molesters, Proulx, Pellerin, Paradis, McKilley, Aubuyt and Ouiment (1997) found the probability of recidivism positively correlated with the number of previous convictions for sexual offenses. They also found a sexual re-conviction rate of 21.2% for rapists and 13% for child molesters over an average of 64.5 months. Hanson's 1997 study showed that prior sexual offenses was the strongest predictor of recidivism. This was also found by Motuik and Brown (1996), and Hanson and Bussière (1996).

Adolescent Recidivism

Evidence for predicting juvenile sexual offender recidivism is diverse. For example, Davis and Leitenberg (1987) studied offense and victim characteristics of adolescent sexual offenders. They compared the recidivism rates of adolescent offenders to adult offenders. They found recidivism rates in adolescents to be lower than rates in adult sex offenders. Smith and Monastersky (1986) also studied the characteristics of juvenile sexual offenders. They found that offenders convicted of rape were less likely to re-offend either sexually or nonsexually. Those offenders whose victims were at least four years younger were less likely to re-offend than those who had victims that were the same

age or older. The offenders who committed offenses against strangers were less likely to re-offend nonsexually but more likely to re-offend sexually than those w ho victimized relatives or acquaintances. Those who victimized males were more likely to recidivate than those who victimized females.

Becker et al. (1988) focussed on the treatment program that adolescent sexual offenders were offered. They studied male adolescent sexual offenders at the Sexual Behaviour Clinic of the New York State Psychiatric Institute. These adolescents were offered a cognitive behavioural treatment program which consisted of verbal satiation, cognitive restructuring, covert sensitization, social skill training, sex education, values clarification, and relapse prevention. The study found that the program was effective in reducing inappropriate sexual arousal in adolescent offenders who were involved with male victims. Becker (1990) found that of the 52 available adolescents who had completed this same treatment 9 % had recommitted sexual crimes. In their overview of the treatment program at Echo Glen Children's Centre in Washington, Kahn and Lafond (1988) found 9% of the sexual offenders recidivate after completing a program using cognitive behavioural strategies such as anger management, sex education, confrontation and journal writing. Borduin, Heggeler, Blaske and Stein (1990) found juveniles who had participated in a multi systemic treatment program recidivated less both sexually and nonsexually than did juveniles who received individual therapy. Kahn and Chambers (1991) found that, following the completion of a eclectic treatment program, 44.8% of the juveniles were convicted of a subsequent criminal offense and 7.5% were convicted of

a subsequent sexual crime.

Healthy Lifestyles

As previously indicated, the Newfoundland and Labrador Youth Centre (NLYC) offers a juvenile sexual offender treatment program. The locally developed program is called "Healthy Lifestyles" (Reid-White, 1997). This program is aimed at providing juvenile sexual offenders who are serving custodial dispositions at the NLYC with skills to maintain a healthy lifestyle free of sexual deviancy. More specifically, the goals of treatment include: deterring subsequent victimization; reducing the likelihood of re-offending behaviour; encouraging positive therapeutic change; and, ultimately providing safety for the community. The philosophy of treatment is based on the beliefs that: offenders are responsible for their behaviour; sex offending is learned behaviour that can be unlearned and/or replaced by different behaviour; sex offending can be treated but not cured; treatment supports prosecution and is not an alternative to prosecution; offenders need to be treated with respect, caution, and assertiveness; and, offenders need to dissolve the secrecy surrounding the sex offence.

As with most programs, it is difficult to define its therapeutic approach. Therapists suggest that Healthy Lifestyles follows a cognitive behavioural approach with a focus on the relapse prevention model. The program is divided into several components, most of which are delivered in a group setting and supplemented with individual counselling sessions. Completion of the entire program usually takes 16 weeks.

The program has a 'closed door' policy. That is, no juvenile sexual offenders are permitted to enter the program once it has started. Prior to starting the program, therapists complete a risk assessment on each participant using Loss and Ross's (1988) 21 assessment factors. The purpose of the assessment is to collect information and attempt to establish a relationship with the juvenile, assist in case dispositions, and define individual treatment goals. Following assessment, juveniles complete the educational component of treatment. It is divided into eight educational sessions which focus on the following topics: (i) anatomy and physiology of human reproductive systems; (ii) growth and development during puberty; (iii) contraception; (iv) sexually transmitted diseases; (v) AIDS; (vi) sex, sexuality, and love; (vii) sexual expression; and, (viii) dating and relationships (Reid-White, 1997). The educational component can exist as a separate entity. It may be determined at this time that juveniles should not proceed with treatment due to lack of maturity, cooperation, or cognitive ability.

Following the educational component, juveniles complete an additional 19 sessions specifically aimed at meeting the individual sexual offender's needs. Sessions are one to two hours in duration, depending upon the needs of group members. These sessions include: coercion and consent, laws around sexual abuse, goal setting, disclosure, victim empathy, preconditions for sexual abuse, cycle of abuse, and relapse prevention. Reid-White indicates that resources utilized in this program have been adopted from the following authors: Kahn (1990); Wells (1990); Richardson, Loss and Ross (1988); Way and Balthazor (1993); Freeman-Longo, Bays and Bear (1996); Finkilhor (1984); Bays

and Freeman-Longo (1989); Way & Balthazor (1990); and, Steen (1993). In addition, there are three individual counselling sessions interspersed throughout these 19 sessions. These sessions are designed to provide participants with an opportunity to identify their personal goals and specific treatment goals, address victimization and 'abused becomes abuser' issues, design individual protection plans through relapse prevention strategies, and complete contracts guaranteeing abstinence from future sexual offenses.

The offering of this program is coordinated with school programming. Two afternoons per week are set aside to provide social development programs as part of the school programming. 'Healthy Lifestyles' is one of these programs. Programs run from September to June.

Treatment Adjunct

Treatment of the juvenile sexual offender extends beyond the realm of the actual treatment program. Ongoing intervention is provided by many facility professionals. Youth Care Counsellors, work with these youth, and are specifically trained to deal with each offender's ongoing issues. Specific interventions by the Youth Care Counsellors may include: aiding the youth in making connections between thoughts, feelings, and behaviours; confronting thinking errors, denial, grooming, and manipulation; helping the youth identify and understand the cycle of abuse; and, encouraging empathy for others. Facility social workers are responsible for counselling on 'everyday issues' and for helping to establish a community network, an important adjunct to treatment (Reid - White

1997). This helps the youth's family, community social worker and other professionals become aware of and involved in the youth's treatment, concerns, and progress. Teachers help reinforce any behavioural expectations and provide additional education in related areas.

Chapter Three

Methodology

Introduction

This chapter describes the subjects, and the data collection procedure. Since program inception, 14 juvenile sexual offenders were treated for sexual offenses while in custody at the NLYC. These offenders completed the Healthy Lifestyles program at different times from April 1994 to October 1997. A retrospective exploratory study was designed to determine the effectiveness of the program by comparing the rate of recidivism of all of these treated juvenile sexual offenders with the recidivism rate of all other juvenile sexual offenders who had been at the NLYC, at the same time, but had not received treatment. The results were further analysed to determine if any particular characteristics were more evident in the re-offenders. The research design of the study was developed to address the research questions identified in Chapter I.

Population

Thirty-two male juveniles who committed sex related offenses and were sentenced to secure custody at the Newfoundland and Labrador Youth Centre were studied. Every male juvenile sexual offender who had resided at the NLYC since April 1994, and whose files were still accessible were included. Their sexual offenses included crimes such as sexual assault, sexual interference, anal intercourse, bestiality, indecent exposure, and incest. Other nonsexual offenses committed, by the same individuals, include: break and enter, uttering threats, aggravated assault, escape from custody, breach of probation, theft, assault, forcible entry, possession of stolen property, failure to comply with recognizance, fraud, robbery with violence, possession of a weapon, and, failure to comply with the courts disposition. Each completed a secure custody disposition at the NLYC, Whitbourne, Newfoundland, Canada in the past six years after committing a sexual crime. The sample included offenders who had been sentenced as long ago as 1992-12-31 and released as recent as 1998-06-28. The age of these juveniles at the time of their offense ranged from 9.0 years to 17.8 years. Their average age at offense was 15.2. Their ages as of September 20, 1998 ranged from 16.5 years to 25.5 years. The average number of sex charges per offender was 1.9, average number of victims was 1.9 and the average number of all prior offenses was 6.3. These thirty-two juvenile sexual offenders were placed in one of three treatment program groups; completed Healthy Lifestyles; not offered Healthy Lifestyles; or, partially completed Healthy Lifestyles.

Treatment Group

The treatment group consisted of the 14 juvenile sexual offenders who completed the Healthy Lifestyles sex offender treatment program at the NLYC. This group was taken from the total population of 32. Each of the 14 juvenile sexual offenders participated in and completed at least one of the six treatment program offerings since April, 1994. The age of these juveniles at the time of their offense ranged from 9.0 years to 17.5 years. Their average age at time of offense was 14.9. Their ages as of September 20, 1998 ranged from 17.9 to 25.5. The average number of sex charges per offender was 1.6, average number of victims was 1.8, and the average number of all prior offenses was 7.3.

Comparison Groups

Two incidental comparison groups were utilized in the study from the remaining 18 juvenile sexual offenders. One comparison group consisted of eight juveniles who had committed sexual offenses but had not been offered the treatment program due to a lack of resources. The age of these juveniles at the time of their offense ranged from 13.0 to 17.7. Their average age at offense was14.9. Their ages as of September 20, 1998 ranged from 16.4 to 22.8. The average number of sex charges per offender was 1.6, average number of victims was 1.1, and the average number of all prior offenses was 6.3.

The second group consisted of the 10 juveniles who had committed sexual offenses, who had started the Healthy Lifestyles program, but did not complete it. All offenders in this group had completed the educational component of the program, but for

varying reasons, did not complete the remainder of the program. These reasons included: length of sentence and nearness of release date, maturity and lower cognitive ability, and commitment to the program. The age of these juveniles at the time of their offense ranged from 13.0 to 17.8. Their average age at offense was 15.8. Their ages as of September 20, 1998 ranged from 16.7 to 23.5. The average number of sex charges per offender was 2.7, average number of victims was 2.7, and the average number of all prior offenses was 4.9.

Group Comparisons

An analysis of variance was performed to determine if there were any significant differences between the three groups on: number of sexual charges, number of all prior offenses, number of sexual priors, and, length at risk. A significance at the $p < .05$ level was required. Three groups of juvenile sexual offenders were compared to determine if there were any differences among the number of sexual charges, number of all prior offenses (includes both sexual and nonsexual offenses), number of sexual prior offenses, and follow-up period. Table 1 shows how the groups differed on the dependent variables. As can be seen from the table, the offenders who partially completed the Healthy Lifestyles program had, on average, more sexual charges than the other two groups. These offenders also had, on average, less prior offenses than the other two groups. Offenders who had completed the Healthy Lifestyles program had, on average, committed the largest number of prior offenses (mean = 7.29). There were very few prior sexual offenses committed (completed Healthy Lifestyles mean = 0.07, not offered Healthy

Lifestyles mean = 6.25, partial Healthy Lifestyles mean = 4.90). Offenders, who had completed the Healthy Lifestyles program had, on average, the longest follow-up period (1013.86 months). Offenders, who had not been offered the Healthy Lifestyles program had the shortest follow-up period (957.40 months).

Table 1

Mean group frequencies on dependent variables

		Influencing Variables			
Group	N	Nsexcha	Npriors	Nsexpr	Follow-up
Completed H/L	14	1.57	7.29	0.07	1013.86
Not offered H/L	8	1.63	6.25	0.00	884.63
Partial H/L	10	2.70	4.90	0.40	957.40

Note. Nsexcha = number of sexual charges; Npriors = number of all priors; Nsexpr = number of sexual priors; Follow-up = post release period calculated in days; H/L = Healthy Lifestyles.

An analysis of variance indicated that there were no significant differences, at the $p<.05$ level, among number of priors, number of sexual priors, and length at risk (see Table 2). There were significant differences found in the number of sexual charges at the $p<.05$ level.

Table 2

Analysis of variance of dependent variables

Variable		Sum of Squares	DF	Mean Square	F	Sig.
Nsexcha	Between Groups	8.471	2	4.236	3.470	.045*
	Within Groups	35.404	29	1.221		
	Total	43.875	31			
Npriors	Between Groups	33.212	2	1.606	0.350	.708
	Within Groups	1377.257	29	4.492		
	Total	86.719	31			
Nsexpr	Between Groups	.890	2	.445	1.384	.267
	Within Groups	9.329	29	.322		
	Total	10.219	31			
Follow-up	Between Groups	85638.729	2	42819.365	0.209	.813
	Within Groups	5953134.000	29	205280.482		
	Total	6038772.700	31			

Note. Nsexcha = number of sexual charges; Npriors = number of priors; Nsexpr = number of sexual priors;

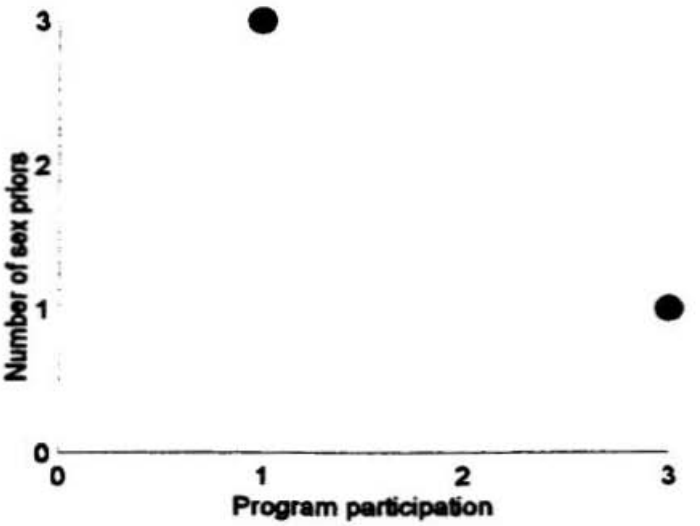
Follow-up = post release follow-up period calculated in days.

*$p<.05$.

Post hoc testing using the Tukey's (Norusis, 1998) honestly significant difference (HSD) revealed that juvenile sexual offenders who had partially completed the Healthy Lifestyles program had significantly more sexual charges than offenders who had completed the Healthy Lifestyles program (see Figure 1).

Figure 1

Tukey HSD multiple comparison test between program groups and number of sex priors



Note. 1 = subjects completed Healthy Lifestyles program;

2 = subjects not offered the Healthy Lifestyles program;

3 = subjects partially completed the Healthy Lifestyles program.

● indicates significant differences between the groups at the $p<.05$ level.

Despite this significant difference on the number of prior offenses, the groups were not different on the other factors. It was felt that further analysis could proceed for the purposes of program evaluation and recommendations to the treatment centre.

Time Frame

The process of identifying and collecting information on each of the 32 juvenile sexual offenders began in the spring of 1998. The Healthy Lifestyles program was first offered in April 1994. All subjects included in this study were in closed custody at the NLYC during or after April 1994. Re-conviction data was collected from date of release to September 20, 1998.

Follow-up

The follow-up period was calculated, for each offender, by subtracting each offender's secure custody release date from September 20, 1998. The length of follow-up ranged from 134 days to 1534 days. The distribution of follow-up period is presented in Table 3.

Procedure for Data Collection

Data collection was performed in the following manner. First, written permission was obtained from the Department of Justice (see Appendix A) to carry out the study. This granted access to each juvenile offender's file to collect background data and

Table 3

Follow-up period for young offenders

Duration	Frequency	Cumulative Percent
Day - 365 Days	5	15.6
366 Days - 730 Days	4	28.1
731 Days - 1095 Days	10	59.4
1096 Days - 1460 Days	7	81.3
1461 Days - 1825 Days	6	100

offense related information, and also provided the researcher with access to both personnel and technological support. Second, written permission was obtained from the Royal Canadian Mounted Police (see Appendix C). This granted access to any data base that was pertinent to gaining an accurate measure of recidivism in juvenile sexual offenders who were older than 18 as of September 20, 1998.

Next, juvenile sexual offenders were identified. The NLYC facility status history print out, accessible through the Young Offenders Information System (YOIS), was used to acquire a list of all juvenile offenders who had been in the facility since April 1994. Juvenile sexual offenders were identified on this printout by facility social workers, nurses and Youth Care Counsellors. A young offender file was then accessed on each of these identified juveniles to assist in the process of ensuring that all identified offenders had

committed a sex related offense. From each of these young offender files a young offender file number was obtained. These file numbers were then entered into the YOIS to get a disposition history printout of each offender to cross reference and ensure that each identified juvenile sexual offender had been convicted of a sex related offense.

Finally, background information, personal information, and criminal history were collected. This information was obtained through the use of the young offender's file and disposition history print out. Each young offender's file was used to collect the following information: a detailed description of the sexual offense; pre-disposition reports; victim impact statements; program participation reports; running logs; birth date; address; community interventions; and family background.

Disposition history printouts were used to identify all criminally convicted offenses and sentence dates for offenders up to their 18th birthday. Conviction numbers were translated using the Criminal Code of Canada (Rodiques and Ouellet, 1996). Any sexually related offenses and their dates were noted. These sexual offenses and their dates were cross referenced with program participation in an attempt to isolate the 'principal' sexual offense(s) for this research. This was necessary because some disposition histories indicated that offenders had been convicted of a sexual offense on more than one occasion. If, for treated offenders, the date of conviction and completion of a closed custody sentence for one sexual offense occurred prior to enrollment in the sexual offender treatment program and occurred prior to sentence conviction of another sexual offense, that sexual conviction was considered a prior sexual offense. However, if

the date of conviction of the sexual offense occurred after enrollment in the sexual offender treatment program and after sentence completion for another sexual offense it was considered a subsequent offense and measured as recidivism. If, for untreated sexual offenders the date of conviction and completion of a closed custody sentence for one sexual offense occurred prior to April 1994, that sexual conviction was considered a prior sexual offense. However, if conviction for all sexual offenses and completion of any closed custody sentence occurred after April 1994 and if the date of conviction for one sexual offense occurred after sentence completion for another sexual offense it was considered a subsequent offense and measured as recidivism. Regardless of treatment, if there was more than one sexual offense and different dates of conviction all sexual offenses were considered the 'principal' sexual offense if the young offender's file indicated that the charges involved the same incident but had been delayed through court proceedings. Any offense that occurred prior to the 'principal' sexual offense conviction date were considered prior offenses. Any offenses that occurred after the conviction and sentence completion for the 'principal' sexual offense were considered a subsequent offence and measured as recidivism. (See Table 4 for an example of one case.) Juvenile sexual offenders were then classified into one of six categories based on the descriptions of prior sexual offenses. These categories were incest offender, child molester, rapist, multiple paraphiliacs, hands off offender, and other.

Table 4

Determining prior, principle, and subsequent sexual and nonsexual offenses

Variables	Date	Principal	Prior	Subsequent
Sexual Offense				
#1 Conviction	95-03-01	Y*	N	N
Secure Custody Duration	95-03-01 - 96-04-26			
#2 Conviction	95-04-27	Y*	N	N
Secure Custody Duration	95-03-01 - 96-04-26			
Nonsexual Offense				
#1 Conviction	93-01-27	N	Y*	N
Secure Custody Duration	N/A			
#2 Conviction	93-03-01	N	Y*	N
Secure Custody Duration	93-03-01 - 93-03-01			
#3 Conviction	94-04-20	N	Y*	N
Secure Custody Duration	N/A			
#4 Conviction	96-08-08	N	N	Y*
Secure Custody Duration	N/A			
Program Participation November 95				

*Offense sentences which run concurrent with program participation were considered principal offenses.

*Offenses occurring before April 1994 were considered prior offenses.

*Offenses that occurred after completion of secure custody and running concurrent with principal offense.

For those offenders who were 18 years or older prior to September 20, 1998, the Canadian Police Information Centre (CPIC) was utilized to trace adult criminal history. To query the CPIC first, a 'persons check' was performed. It required the offender's name and birth date. The persons check generated a fingerprint number. Next, the fingerprint number was used to perform a 'criminal records check'. The criminal records check generated a 'convictions and discharges' summary data sheet. All convictions identified here automatically indicated that the offender had re-offended because it presupposes that the offender had been released from youth custody. If this criminal records check revealed that the offender had committed subsequent sexual offenses, a 'police file sheet' was obtained to get the specifics surrounding the offense.
Once the offense history of each offender was obtained, the length of time until re-conviction was tabulated.

Recidivism Rates

Recidivism rates were determined by re-convictions of subsequent sexual and nonsexual offenses as per the Criminal Code of Canada. An offense was established as subsequent using the procedure as outlined in the 'procedure for data collection' section. A Pearson chi square (Norusis, 1998) was used to determine if there were any significant differences among the three groups. A significance at the $p < .05$ level was required. A Pearson chi square was also used to determine if typology, number of priors, sex of victim, or, relationship of victim affected recidivism. A significance at the $p < .05$ level was required.

Chapter Four

Results

This chapter deals with an analysis of the data collected from each subject's file and criminal record.

The relationship between level of the treatment program and sexual recidivism

Of the entire 32 juvenile sexual offenders, only 1 re-offended sexually. This accounted for 3.1% of the total sexual offender population. 96.9 % of the population did not re-offend sexually. The relationship between treatment program and sexual recidivism is shown in Table 5. As can be seen in the table, the juvenile sexual offender who had sexually re-offended had not been offered the Healthy Lifestyles program. Due to this single occurrence of sexual re-offending, there will be a closer examination of this sexual re-offender later in this report.

Table 5

Relationship between level of treatment program and sexual recidivism

Treatment	N	Sexual Recidivism Yes	No	Total
Completed H/L	14	0 0%	14 100%	100%
Not offered H/L	8	1 12.5%	7 87.5%	100%
Partial H/L	10	0 0%	10 100%	100%
Total		1 3.1%	31 96.9%	

Note. H/L = Healthy Lifestyles sexual offender program.

The relationship between level of treatment programs and nonsexual recidivism

The relationship between the level of the treatment program and nonsexual recidivism is shown in Table 6. As can be seen, offenders who had not been offered the

Table 6

Relationship between level of treatment program and nonsexual recidivism

		Nonsexual Recidivism		
Treatment	N	Yes	No	Total
Completed H/L	14	5	9	
		35.7%	64.3%	100%
Not offered H/L	8	6	2	
		75.0%	25.0%	100%
Partial H/L	10	4	6	
		40.0%	60.0%	100%
Total		15	17	
		46.9%	53.1%	

Note. H/L = Healthy Lifestyles sexual offender treatment program.

$x^2 = 3.431$, df = 2, p = 180.

Healthy Lifestyles program, had the largest percentage nonsexual re-offending. Juveniles who had any exposure to the Healthy Lifestyles program re-offended non-sexually at lower rates.

However, a further Pearson chi-square analysis (Norusis, 1998) revealed that there were no significant differences at the $p<.05$ level, between the level of treatment program

and nonsexual re-conviction. The probability that sexual offenders would re-offend nonsexually was not influenced by the completion of the Healthy Lifestyles program.

The relationship between the rate of sexual recidivism and nonsexual recidivism

The relationship between the rate of sexual recidivism and the rate of nonsexual recidivism is shown in Table 7. As can be seen the juvenile sexual offender who recidivated sexually also recidivated nonsexually. A large percentage (45.2) of those juvenile sexual offenders who did not re-offend sexually did re-offend nonsexually. However, a chi-square analysis revealed that there were no significant differences, at the $p<.05$ level, between sexual recidivism rates and nonsexual recidivism rates.

Table 7

Relationship between the rate of sexual and nonsexual recidivism

		Sexual Recidivism	
Nonsexual Recidivism		Yes	No
Yes	Number	1	14
	%	100%	45.2%
No	Number	0	17
	%	0%	54.8%
Total		1	31
		100%	100%

Note. $x^2 = 1.170$, $df = 1$, $p = .279$.

The relationship between nonsexual recidivism and prior convictions, typology, victim relationship, and sex of victim

It was necessary to determine if certain variables correlated with nonsexual

recidivism. The explored factors included, prior convictions, typology, victim relationship, and sex of victim.

All prior convictions

The relationship between all prior convictions and nonsexual recidivism is shown in Table 8. As can be seen from the table, 50 % (N = 7) with 1 to 5 prior offenses re-offended. 100% (N = 6) of those offenders who committed more than 11 prior offenses re-offended nonsexually. Juveniles who had not committed any prior offenses (0) and those juveniles who had committed 6 to 10 prior offenses re-offended nonsexually at a low rate, 16.7% (N = 1).

Table 8

Relationship between all prior convictions and nonsexual recidivism

Nonsexual Recidivism		Npriors			
		0	1 - 5	6 - 10	11 +
Yes	Number	1	7	1	6*
	%	16.7%	50.0%	16.7%	100%
No	Number	5	7	5	0
	%	83.3%	50.0%	83.3%	0%
Total		6	14	6	6
		100%	100%	100%	100%

Note. $x^2 = 11.252$, $df = 3$, $p = .010$.

*$p < .05$.

A Pearson chi-square (Norusis, 1998) analysis revealed that there were significant differences, at the $p<.05$ level, between number of prior convictions and nonsexual recidivism.. Juvenile sexual offenders who had been convicted of 11 or more previous offenses re-offended nonsexually more than juveniles who had committed no previous offenses.

Prior sexual offenses

The relationship between prior sexual convictions and nonsexual recidivism is shown in Table 9. As can been seen in the table, all juvenile sexual offenders, who had re-offended nonsexually, did not have any prior sexual convictions (N = 15). A chi-square analysis revealed that there were no significant differences, at the $p<.05$ level, between number of sexual prior offenses and nonsexual recidivism.

Table 9

Relationship between nonsexual recidivism and prior sexual convictions

		Nsexpriors		
Nonsexual Recidivism		0	1	3
Yes	Number	15	0	0
	%	50.0%	0%	0%
No	Number	15	1	1
	%	50.0%	100%	100%
Total		30	1	1
		100%	100%	100%

Note. $x^2 = 1.882$, $df = 2$, $p = .390$.

Typology

The relationship between typology and nonsexual recidivism is shown in Table 10. As can be seen in the table, child molesters re-offended less frequently (N = 9). Juveniles, who were charged with either fondling, or anal intercourse (classified as 'other') re-offended more often (N = 5). A Pearson chi-square (Norusis, 1998) analysis revealed that there were no significant differences, at the $p<.05$ level, between typology and recidivism.

Victim Relationship

The relationship between recidivism and victim relationship is shown in Table 11. As can be seen, juvenile sexual offenders who committed sexual crimes against victims whom they babysat did not re-offend nonsexually. Those juveniles who committed crimes against nieces, cousins, or nephews, and juveniles who committed crimes against a combination of victims committed more nonsexual re-offenses nonsexually. However, Pearson chi-square (Norusis, 1998) analysis revealed that there were no significant differences, at the $p<.05$ level, between relationship of victim and recidivism.

Table 10

Relationship between typology and nonsexual recidivism

Nonsexual Recidivism		Typology					
		Incest offender	Child molester	Rapist	Hands-off offender	Multiple	Other
Yes	Number	1	3	3	1	2	5
	%	33.3%	25.0%	50.0%	50.0%	66.7%	83.3%
No	Number	2	9	3	1	1	1
	%	66.7%	75.0%	50.0%	50.0%	33.3%	16.7%
Total		3	12	6	2	3	6
		100%	100 %	100%	100%	100%	100%

Note. $x^2 = 6.233$, df = 5, p = .284.

Table 11

Relationship between nonsexual recidivism and victim relationship

Nonsexual Recidivism		Victim Relationship					
		Intrafamilial	Extrafamilial	Babysitter	Known/not family	Other	Combination
Yes	Number	2	2	0	5	2	2
	%	50.0%	66.7%	0%	41.7%	40.0%	66.7%
No	Number	2	1	1	7	3	1
	%	50.0%	33.3%	100 %	58.3%	60.0%	33.3%
Total		2	2	1	1	5	3
		100%	100%	100%	100%	100%	100%

Note. $x^2 = 2.068$, $df = 5$, $p = .840$.

Sex of victim

The relationship between sex of victim and recidivism is shown in Table 12.

Table 12

Sex of victim and nonsexual recidivism

Nonsexual Recidivism		Sex of victim			
		Female	Male	Both	Beast
Yes	Number	12	2	1	0
	%	54.5%	50.0%	20.0%	0%
No	Number	10	2	4	1
	%	45.5%	50.0%	80.0%	100%
Total		22	4	5	1
		100%	100%	100%	100%

Note. $x^2 = 2.868$, $df = 3$, $p = .412$.

As can be seen in the table, juvenile sexual offenders, who had sexually offended against both males and females , showed the greatest difference in re-offense history. A larger percent of these juveniles committed nonsexual re-offenses (80.0%). Of the juveniles, who originally offended against either a female or a male, a similar number was found to commit further nonsexual offenses as was not found to commit any further offenses. The juvenile who committed an offense against an animal did not re-offend nonsexually. However, a Pearson chi-square (Norusis, 1998) analysis revealed that there were no significant differences, at the $p<.05$ level, between sex of victim and recidivism.

The relationship between group follow-up and nonsexual recidivism

The relationship between length of group follow-up and juvenile sexual offender recidivism is shown in Table 13. A Pearson correlation (Norusis, 1998) test revealed no significant correlation between any of the four groups. However there was a significant correlation for the group that had not been offered the Healthy Lifestyles sexual offender program. As Figure 2 indicates, offenders, who had not been exposed to any of the treatment program, were more likely to recidivate nonsexually as the follow-up period increased.

Table 13

Relationship between group follow-up period and nonsexual recidivism

		Group follow-up			
Variable	Correlation	Sample	Not offered H/L	Not offered H/L	Partial H/L
Nonsexual Recidivism	Pearson	-.085	.310	-.854**	-.472

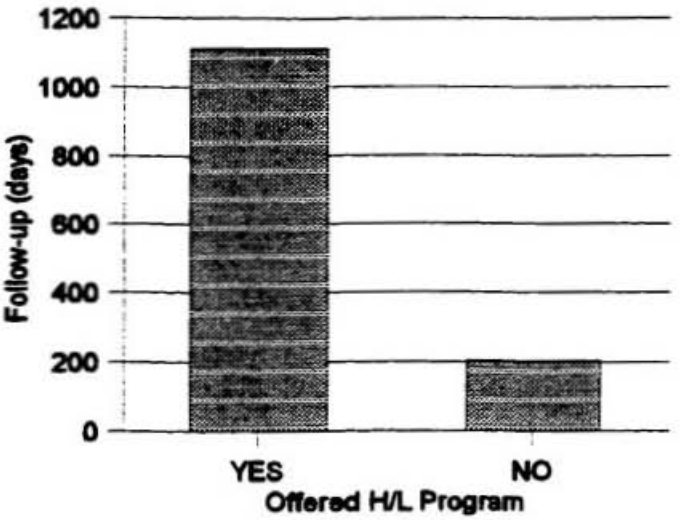
Note. H/L = Healthy Lifestyles sexual offender program.

Correlations were performed on each group.

** Correlation is significant at the 0.01 level.

*p<.05.

Figure 2. Average follow-up period for juvenile sexual offenders who had not been offered the Healthy Lifestyles program.



Since I found that only one juvenile sexual offender re-offended sexually, it is important to discuss this juvenile recidivist in detail. It is important to determine if this sexual recidivist possessed any characteristics which may help us in identifying future sexual offenders.

Treatment Group

As previously indicated in Table 6, the sexual recidivist was 1 of 8 juvenile sexual offenders who had not been offered the Healthy Lifestyles program. This occurred for several reasons: he spent less than 40 consecutive days in secure custody at the Newfoundland and Labrador Youth Centre for his principal sexual crime; he was sentenced during the summer months; and, time of sentencing and sentence duration did not correspond with the availability of the Healthy Lifestyles program.

Nonsexual Recidivism

The juvenile sexual recidivist was also 1 of 15 who re-offended nonsexually. He was convicted of uttering threats.

The relationship between number of prior convictions and nonsexual recidivism

The juvenile recidivist had been convicted of 2 prior criminal nonsexual offenses. He was 1 of 7 who re-offended nonsexually.

The relationship between number of prior convictions and sexual recidivism

All prior convictions

The relationship between number of priors and sexual recidivism is shown in

Table 14.

Table 14

Relationship between number of all priors and sexual recidivism

Sexual Recidivism		Number of priors 0	1 - 5	6 - 10	11 +
Yes	Number	0	1	0	0
	%	0%	7.1%	0%	0 %
No	Number	6	13	6	6
	%	100%	92.9%	100%	100%
Total		6	14	6	6
		100%	100%	100%	100%

As can be seen in the table, the sexual recidivist committed 1 to 5 prior offenses. A large percentage of those offenders who had committed the same number of offenses (92.9%) did not re-offend sexually. There was no indication, based on the number of priors committed by each offender, that a sexual re-offense was likely.

Sexual priors

The relationship between sexual prior offenses and sexual recidivism is shown in Table 15. As can be seen in the table, the sexual recidivist did not commit any sexual prior offenses. Only 2 juvenile sexual offenders had committed prior sexual offenses. These offenders did not re-offend sexually.

Table 15

Relationship between number sexual priors and sexual recidivism

Sexual Recidivism		Number of sexual priors 0	1	3
Yes	Number	0	0	0
	%	0%	0%	0%
No	Number	30	1	1
	%	100%	100 %	100%
Total		30	1	1
		100%	100%	100%

The relationship between typology and sexual recidivism

The sexual recidivist was 1 of 6 juvenile sexual offenders who were classified as 'other' on the typology variable. He was convicted of fondling a victim who was less than five years younger. The relationship between typology and sexual recidivism is shown in Table 16. As can be seen in the table, there was no indication, based on the type of sexual offense committed to suggest that a sexual re-offense was likely. Juveniles who had committed incest offenses; child molestation offenses; rapes; offenses such as voyeurism, obscene phone calls, and exhibitionism; multiple offenses; or, offenses such as fondling and anal intercourse, were not likely to commit a further sexual offense. Therefore the sexual recidivist, in this instance, apparently, was no more likely to commit a sexual offense because of his typology.

Table 16

Relationship between typology and sexual recidivism

		Typology					
Sexual Recidivism		Incest offender	Child molester	Rapist	Hands-off offender	Multiple	Other
Yes	Number	0	0	0	0	0	1
	%	0%	0%	0%	0%	0%	16.7%
No	Number	3	12	6	2	3	5
	%	100%	100%	100%	100 %	100%	83.3%
Total		3	2	6	2	3	6
		100%	100%	100%	100%	100%	100%

The relationship between sex of victim and sexual recidivism

Twenty-two juvenile sexual offenders had chose female victims. The sexual recidivist was 1 of 12 of these who re-offended nonsexually. The relationship between sex of victim and sexual recidivism is shown in Table 17. As can be seen from the table, the sexual recidivist offended against a female victim. 95.5% of those juveniles who had female victims did not re-offend. This indicates that the juvenile recidivist apparently did not re-offend because of the sex of his victim. Juvenile sexual offenders who had committed offenses against males, both sexes, or beasts did not re-offend sexually. Interestingly, the juvenile recidivist re-offended against another female victim.

Table 17

Cross tabulation of sex of victim and sexual recidivism

Sexual Recidivism		Sex of victim: Female	Male	Both	Beast
Yes	Number	1	0	0	0
	%	4.5%	0%	0%	0%
No	Number	21	4	5	1
	%	95.5%	100%	100%	100%
Total		22	4	5	1
		100%	100%	100%	100%

The relationship between follow-up and recidivism

In the previous results, it was shown that follow-up and recidivism did correlate among juvenile sexual offenders who had been not offered the treatment program. The juvenile recidivist had not been exposed to the treatment program. He had a lengthy follow-up of 1461 days, well above the average of 1112 for the group not offered the treatment program. The relationship between follow-up and sexual recidivism is shown in Table 18. A Pearson correlation (Norusis, 1998) revealed that there were no significant differences, at the $p<.05$ level, between follow-up and sexual recidivism. Even though the juvenile recidivist had a lengthy follow-up he did not commit a sexual re-offense.

Table 18

Relationship between group follow-up and sexual recidivism

		Group follow-up			
Variable	Correlation	Sample	Completed H/L	Not offered H/L	Partial H/L
Sexual recidivism	Pearson	-.085	•	-.472	•

Note. • Cannot be computed because at least one of the variables is constant.

Correlations were performed on each group.

'$p<.05$.

Further Exploration

Several additional factors were explored in an attempt to determine any distinctive characteristics that may have indicated a future sexual offense. These factors are presented in a Table 19. As can be seen, the juvenile sexual recidivist had four average scores below the rest of the group. His age at the time of first sexual offense was younger than the average of the remainder of the sample. The average number of total sexual convictions for the juvenile sexual recidivist was slightly less than the remainder of the sample. The juvenile sexual offender is currently younger than the average of the remainder of the sample, which may have some serious implications for the urgency of future programming for him.

There were other areas where the juvenile recidivist had scores above the mean score for the remainder of the group. The juvenile recidivist was tracked for a much longer time than the remainder of the sample. His length of follow-up was greater than one standard deviation above the remainder of the sample. The juvenile recidivist also had a slightly higher number of victims than the remainder of the group (2.00 versus 1.90).

Table 19

Comparison of additional variables between sexual recidivist and rest of sample

Variable	Subject	Mean	SD
Age1sex	Juvenile Recidivist	14.00	
	Others	15.23	2.09
Nsex	Juvenile Recidivist	2.00	
	Others	2.06	1.34
Follow-up	Juvenile Recidivist	1461.00	
	Others	947.87	439.08
Durclose	Juvenile Recidivist	106.00	
	Others	327.13	225.19
Nvic	Juvenile Recidivist	2.00	
	Others	1.90	1.70
Agenow	Juvenile Recidivist	18.00	
	Others	20.29	2.48

Note. Others = entire sample excluding juvenile recidivist; Age1sex = age of offender at first sexual offense; Nsex = number of total sexual convictions; Durclose = duration spent in closed custody; Nvic = number of victims; Agenow = age of offender as of September 20, 1998.

Summary

This study tracked 32 juvenile sexual offenders who had been sentenced to secure custody at the Newfoundland and Labrador Youth Centre: 14 who had completed the Healthy Lifestyles program; 8 who had not been offered the program; and, 10 who had partially completed the Healthy Lifestyles program. These young offenders were tracked for an average of 964 days after release. The results were as follows: the overall sexual recidivism rate for those who completed the treatment program was 0%; for those not offered the treatment program it was 12.5%; and, for those who partially completed the program 0%. The nonsexual recidivism rate was 35.7%, 75%, and 40% respectively. Results indicated that 100 % of the offenders who had committed 11 or more prior offenses re-offended. A Pearson correlation revealed that, for those not offered the treatment program, the likelihood of re-offending increased as the length of follow-up increased. Further probing into other factors related to the one juvenile sexual recidivist revealed that he had started sexually offending at a younger age, had spent a shorter period in closed custody, had been tracked for a much longer period of time, and is presently younger than most others in the sample. It is not known if these differences are significant.

Chapter 5

Discussion

The study evaluated the effectiveness of a juvenile sexual offender program, Healthy Lifestyles, in reducing sexual and nonsexual recidivism. Three groups, with varying degrees of program completion were used. Group 1 consisted of 14 juvenile sexual offenders who had completed the Healthy Lifestyles program. Group 2 consisted of 8 juvenile sexual offenders who had not been offered the Healthy Lifestyles program. Group 3 consisted of 10 juvenile sexual offenders who had completed the educational component of the Healthy Lifestyles program. Initially, these groups were compared on several factors to determine if there were any differences among the groups. It was revealed that juvenile sexual offenders, who partially completed the program, had significantly more officially recorded sexual charges than the juveniles who had completed the program. Even though the groups differed on one factor, the study was continued because of the value it would have for future sexual offender programs and programming at the Newfoundland and Labrador Youth Centre.

There were five research questions investigated in the study. The first three research questions focussed specifically on the rate of recidivism for both sexual and nonsexual re-offenses.

Hypothesis 1 stated that sexual offenders who completed the Healthy Lifestyles

program would have a lower sexual recidivism rate than the sexual offenders who did not complete the program. The research revealed that there was only one sexual re-offender in the sample. This sexual recidivist was 1 of 8 not offered the Healthy Lifestyles program. The results indicated that juveniles who had any exposure to the Healthy Lifestyles program had no sexual recidivism. As previously indicated, there were two groups exposed to the Healthy Lifestyles program. One group completed the program, whereas, the other completed only the educational component. This educational component was designed to address both cognitive and informational distortions that juvenile sexual offenders may have regarding sexuality. A sexual recidivism rate of 0% suggests that we may be cautiously optimistic in saying that the educational component, and the completion of the Healthy Lifestyles program, were effective in reducing the sexual re-conviction rate.

Hypothesis 2 stated that sexual offenders, who completed the Healthy Lifestyles program, would have a lower nonsexual recidivism rate than sexual offenders who did not complete the program. Research suggested that juvenile sexual offenders, who were given any exposure to the Healthy Lifestyles program, had a lower nonsexual recidivism rate than sexual offenders who did not complete the program. It was found that 75% (6/8) of the offenders, who were not offered the program, re-offended non-sexually. For the completed Healthy Lifestyles group and the partially completed Healthy Lifestyles group, the rates were 35.7% (5/14) and 40.0% (4/10) respectively. Offenders, with any program exposure, were 35 - 40 % less likely to reoffend non-sexually than offenders who were not

exposed to the Healthy Lifestyles program. This indicated that the educational component, as well as, the entire Healthy Lifestyles program, may have been effective in lowering non-sexual recidivism.

Hypothesis 3 stated that there would be a lower rate of sexual recidivism than nonsexual recidivism for both the treated and untreated offenders. The sexual recidivism rate was much lower than the nonsexual recidivism rate, without regard for treatment groups. Not surprisingly, the results found a sexual recidivism rate of 3.1%, and a nonsexual recidivism rate of 46.9%. In this particular study, it is important to remember that only one juvenile sexual offender sexually recidivated. The results are consistent with other research (Motiuk & Belcourt, 1996; Hanson & Bussière, 1996). The Criminal Code reveals that there are many more nonsexual charges, as compared to sexual convictions, for offenders. Based on sheer number of possible offenses, the likelihood of an offender to be charged with an additional sexual offense, is much lower than the likelihood of the offender to be charged with an additional nonsexual offense. The likelihood of an offender to be convicted of an additional sexual offense also decreases as the plea bargaining process begins.

Hypothesis 4 stated that juvenile sexual offenders with prior sexual offenses would have a higher rate of sexual recidivism. Juveniles with prior sexual offenses were thought to have more ingrained patterns of sexual deviancy and thus more likely to commit further sexual offenses. In this study, only two juvenile sexual offenders had prior sexual offenses. These juveniles did not re-offend sexually. The sexual recidivist had not

committed a prior sexual offense. The relationship between previous sexual offenses and nonsexual re-conviction was also investigated. Neither of these two juveniles committed any further nonsexual crimes. Based on the re-offending rate of juveniles, who had prior sexual convictions, it appears that juveniles with prior sexual offenses did not re-offend, either sexually or nonsexually. These results were surprising. They are inconsistent with results found by Hall (1988), Hanson et al. (1992), Marshall and Barbaree (1988), Quinsey (1996). Previous studies have found the existence of a previous sexual offense to be one of the best predictors of future sexual offending.

A further investigation into the criminal history of the juvenile sexual offenders revealed that all prior convictions, sexual and nonsexual, did not predict sexual recidivism. However, a relationship was established between the total number of prior offenses and the likelihood of nonsexual recidivism. The greater the number of prior convictions the greater the likelihood that the offender would commit a further nonsexual offense. This finding supports the theory that established patterns of delinquency is a good predictor of recidivism (Knopp, 1995; Knopp & Lane, 1991).

Hypothesis 4 also stated that rapists would have a higher rate of nonsexual recidivism. The data did not support this hypothesis. Rapists were equally likely to re-offend nonsexually. As compared to the other types of offenders, they were no more likely to commit a further nonsexual offense. Also, the rapists did not re-offend sexually. Smith and Monastersky (1986) also found that rapists were less likely to re-offend either sexually or nonsexually. This study did reveal that offenders who committed offenses such

as, fondling or anal intercourse (other) re-offended nonsexually at a higher rate. It is interesting to note that the sexual recidivist was also categorized in this typology. In summary, the offenders who committed offenses such a fondling or anal intercourse re-offended either sexually or nonsexually more often but not at a significant level.

Hypothesis 5 stated that as the follow-up period increased, so too would the recidivism rate. The results supported this hypothesis. Specifically, those offenders who were not offered the Healthy Lifestyles program, re-offended more nonsexually as the follow-up period increased. This suggests that incarceration, alone, is not as effective as incarceration supplemented by sexual offender treatment. This is consistent with results found by researchers such as Dwyer (1997), Gibbens, Soothill and Way (1981), Barbaree (1997), Fisher (1994), and Williams (1996). It is interesting to note that the lone juvenile sexual recidivist also had a lengthy follow-up. However, because of the low sexual recidivism rate a correlation between sexual recidivism and follow-up could not be found.

In addition to the investigation of these five hypothesis, a case study of the juvenile sexual recidivist was performed. A closer examination of the juvenile sexual re-offender's number of prior convictions, number of prior sexual convictions, typology, sex of victim, follow-up duration, number of victims, number of sexual offenses, age at first offense, age now, and duration in closed custody did not indicate any significant differences between the sexual re-offender and others in the sample. There appeared to be no predetermining factors to suggest that this particular juvenile sexual offender was more likely to commit an additional sexual offense upon release.

Recommendations

Based on the results of the research in conjunction with an examination of the delivery of the Healthy Lifestyles program at the Newfoundland and Labrador Youth Centre, the following recommendations are made.

1. The educational component of the Healthy Lifestyles program should be offered to every juvenile offender.

Since all sexual offenders exposed to the Healthy Lifestyles program completed the educational component of the program, maybe completion of only this component would be effective in lowering recidivism. The educational component consists of only eight sessions and is normally completed within one month but, at times, has been completed in a much shorter duration if necessary. As earlier stated, some sexual offenders were not offered any components of the Healthy Lifestyles program because of a lack of resources and inconsistencies between sentence duration and program offerings. Commitment to offer, only, the educational component would increase the possibility of reaching more sexual offenders during their period of incarceration. Furthermore, the issues covered in the educational component of the Healthy Lifestyles program are designed to provide all juveniles with information that could help clarify any cognitive/informational distortions they may have regarding sexuality. All juvenile offenders could benefit from the information presented in the material. Results of the present study indicated that this component may have reduced the likelihood of re-offending nonsexually. Certainly, given the high recidivism rate of juvenile sexual offenders, this could be helpful.

This is not to suggest that the Healthy Lifestyles program, in its entirety, should be discontinued. Caution should be exercised when contemplating a change to a program. Such a change can have major implications for the juvenile offenders and their potential victims. One cannot conclude that completion of the educational component was sufficient for any of the juvenile sexual offenders, especially the 14 juvenile sexual offenders who had completed the Healthy Lifestyles program. It is quite possible that these 14 offenders needed these additional components to assist in their resistance of a return to sexual deviancy. Depriving these offenders, or others like them, from the additional components of the Healthy Lifestyles program may put society at an unnecessary risk. If the resources are available, and the time allows, these juveniles should be offered the program.

2. Utilize other personnel at the Newfoundland and Labrador Youth Centre to deliver the program.

Although the issue of personnel was not addressed in the study, the possibility of utilizing other personnel to deliver this component should be explored. Utilizing personnel, other than the sexual offender program therapist, may be very beneficial in creating a flexible schedule for the deliverance of the program. Juvenile sexual offenders are in housed in the facility twenty-four hours of the day, seven days of the week. The personnel, traditionally utilized for the deliverance of the program, work 9 - 5, Monday to Friday. Unfortunately, most young offenders are in school 9 - 3, Monday to Friday. Utilizing other personnel who are not limited to the 9 - 5 schedule could aid in offering the

program more frequently.

3. The Newfoundland and Labrador Youth Centre could change its 'closed door' policy for the Healthy Lifestyles program.

As presently implemented, the Healthy Lifestyles program does not permit any new participants into the program once the program sessions have begun. As was previously stated, the first month of the program entails the completion of the educational component. This is the component which this research suggests may be the key link in curbing future re-offending. It is intended to provide the juvenile sexual offender with the foundation to understand sexual terms that may be discussed in later sessions. Juvenile sexual offenders should be given every opportunity to avail of the information presented in this component. It is important, however, to remember that this may jeopardize group cohesion and group dynamics.

4. The judge should issue secure custody sentencing in collaboration with program therapists at the Newfoundland and Labrador Youth Centre.

To address the lack of consistency between juvenile sexual offender sentencing and program offerings, judges should collaborate with program therapists at the Newfoundland and Labrador Youth Centre. Judges could then issue sentences that ensure that the juvenile sexual offender could avail of the rehabilitative program.

Limitations

The limitations of the present study include recidivism measure, length of offender follow-up, sample size, and environmental changes.

Recidivism measure

The recidivism rate of the juvenile sexual offenders was determined by examining the re-conviction rate of the offender. This may not be a true representation of the recidivism rate because of under reporting, plea bargaining, and data entry processing. Under reporting is very common with regards to sexual offenses. Adults choose not to report because of embarrassment, uncertainty, and fear of the legal implications. Most sexual assaults against children are never reported (Bonta & Hanson, 1994). In addition, sexual offenders can not be expected to admit to these offenses themselves.

To ensure conviction of the offender, charges are often reduced to something other than a sexual offense. For example, a sexual assault may be reduced to a charge of an assault. From the offender's perspective this is beneficial because he or she may avoid a more lengthy disposition sentence. From the victim's perspective it may also be beneficial because he or she may avoid embarrassing court proceedings.

The utilization of the re-conviction rate to determine the recidivism measure of juvenile sexual offenders may have provided an underestimated value. Therefore an improved study would include interviewing the juvenile sexual offenders to get personal accounts of their criminal activity.

Follow-up

The average follow-up duration for the offenders was 964 days, with a range from 134 days to 1568 days. This was due to differential release dates of program participants from secure custody. The length of follow-up directly influences the recidivism rate (Hanson, 1992; Hanson, 1997; Dwyer, 1997). Specifically, Hanson (1992) found the recidivism rate to be higher between the fifth and tenth years following release. The offenders in this study were tracked for a much shorter duration. We should thus be cautious as to how we interpret any outward signs of success. Unfortunately, when studying juvenile offenders, research is limited by the Young Offenders Act. After a specific time, information available on juveniles is destroyed.

An improved study would follow these juvenile offenders for an additional period of time. A longitudinal study which follows the offender for an additional ten years may produce more reliable data.

Sample size

The sample consisted of 32 juvenile sexual offenders who had been sentenced to secure custody at the Newfoundland and Labrador Youth Centre. This included all sexual offenders, who had accessible files, and had been in secure custody at the NLYC since April 1994. Cohen (1988), recommended a sample size as large as 200 per group to detect treatment effects. Unfortunate for research, but fortunate for society, finding such a large number was impossible, therefore, one should cautiously generalize the results of this study.

An improved study would broaden its sample by including all juvenile sexual offenders in Newfoundland who had completed a juvenile sexual offender treatment program.

Environmental changes

During the four year period of study, two very important changes occurred which may have impacted upon the results. In 1995, one year after Healthy Lifestyles became available at the Newfoundland and Labrador Youth Centre, the facility adopted a program driven approach. This meant that all sexual offenders were housed in the same living quarters. This fostered an environment where Youth Care Counselling staff could deal with these sexual offenders and their issues. Intervention was no longer limited to the specifics of the Healthy Lifestyles program, but became a part of daily living. This meant that offenders, who completed the program prior to 1995, had been offered only the Healthy Lifestyles program. For them, the program was an entity apart from daily living.

Also in late 1995, several changes were made to the Young Offenders Act (YOA). The Young Offenders Act (s.24.1(1)) states that a young offender shall be given closed custody when all other available alternatives have been exhausted. This changed the sentencing patterns of judges and in turn changed the type/amount of offenses for which an offender was given closed custody. There were two obvious implications. First, young offenders, sentenced prior to the implementation of the YOA changes, may have more likely been more easily given closed custody dispositions and may have had short criminal histories. Closed custody dispositions wee not the last alternative. Second, juvenile

sexual offenders sentenced, following YOA changes, may have had more lengthy criminal histories. Judges for offenders who were sentenced following the YOA changes were required to explore every option available before considering closed custody.

Unfortunately, control for such external variables is nearly impossible. The study included all sexual offenders who had been at the Newfoundland and Labrador Youth Centre. Grouping of the subjects was predetermined by the amount of exposure to the treatment program.

Further Research Suggestions

Some of the limitations experienced in this research offer guides for further research.

1. Further studies should include a minimum post release follow-up period of five years. Hanson (1992) found the greatest risk of recidivism occurred when the follow-up period was between five and ten years. Offenders of this study could continue to be monitored for a longer period to determine if the recidivism rate increases with follow-up.

2. Increase the sample size. Future researchers could compare juvenile sexual offenders who avail of programs offered in facilities throughout the country. Hopefully, this would allow the researcher to establish a large sample.

References

Barbaree, H. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. *Sexual Abuse: A Journal of Research and Treatment, 9* (2), 111-127.

Barbaree, H. E., Hudson, S. M., Seto, M. C. (1993). Sexual assault in society: The role of the juvenile offender. In H. Barbaree, W. Marshall & S. Hudson (Eds.), *The Juvenile Sex Offender* (pp. 1-24). New York, NY: The Guilford Press.

Barbaree, H. E., Marshall, W. L. & Hudson, S. M. (1993). *The Juvenile Sex Offender*. London: The Guilford Press.

Bays, L., & Freeman - Longo, R. (1989). *Why Did I Do It Again? Understanding my Cycle Problem Behaviours*. VT: Safer Society Press.

Becker, J. V. (1988). Adolescent sex offenders. *The Behaviour Therapist*, 11 (9), 185-187.

Becker, J. V. (1990). Treating adolescent sexual offenders. *Professional Psychology: Research and Practice, 21(5)*, 362-365.

Becker, J. V., Harris, C. D., & Sales, B. D. (1993). Juveniles who commit sexual offenses: A critical review of research. In G. Hall, R. Hirschman, J. Graham, & M. Zaragoza (Eds.), *Sexual Aggression: Issues in Etiology, Assessment and Treatment* (pp. 215-228). Washington, DC: Taylor & Francis.

Becker, J. V., & Kaplan, M. S. (1993). Cognitive behavioural treatment of the juvenile sex offender. In H. Barbaree, W. Marshall & S. Hudson (Eds.), *The Juvenile Sex Offender* (pp. 264-276). New York, NY: The Guilford Press.

Becker, J. V., Kaplan, M. S. & Kavoussi, R. (1988). Measuring the effectiveness of treatment for the sexual offender. In R.A. Prentky & V. L. Quinsey (Eds.) *Human Sexual Aggression: Current Perspective* (Vol. 528, pp. 215-234). New York: The New York Academy of Sciences.

Bentovim, A. (1991). Clinical work with families in which sexual abuse has occurred. In C. R. Hollin, & K. Howells (Eds.), *Clinical Approaches to Sex Offenders and Their Victims* (pp.179-208). Chichester: John Wiley & Sons.

Blanchette, K. (1996). *Sex Offender Assessment, Treatment and Recidivism: A Literature Review* (N°. R-48). Ottawa, Ontario: Correctional Services Canada.

Bonta, J., & Hanson, R. K. (1994). *Gauging the risk for violence: Measurement, impact and strategies for change (No. 1994-09).* Ottawa, Ontario: Department of the Solicitor General of Canada.

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multi-systemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 34,* 105-113.

Bradford, J. M. W. (1993). The pharmacological treatment of the adolescent sex offender. In H. E. Barbaree, W. L. Marshall & S. M. Hudson, *The Juvenile Sex Offender* (pp.278-288). New York: The Guilford Press.

Burnett, R., & Rathbun, C. (1993). Discovery and treatment of adolescent sexual offenders in a residential treatment centre. *Residential Treatment for Children and Youth, 11(2),* 57-64.

Charles, G., & McDonald, M. (1997). Adolescent sexual offenders. *Journal of Child and Youth Care, 11 (1),* 15-25.

Cohen, J. (1988). *Statistical power analysis for behavioural sciences (2nd ed.)*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Coleman, H. (1997). Gaps and silences: the culture and adolescent sex offenders. *Journal of Child and Youth Care, 11 (1),* 1-13.

Committee on Sexual Offenses Against Children and Youth. (1984). *Sexual offenses against children, Vol.1.* Ottawa, Canada: Canadian Government Publishing Centre.

Cooper, M. (1994). *Setting standards and guiding principles for the assessment, treatment and management of sex offenders in British Columbia.* Vancouver, BC: BC Institute on Family Violence.

Davis, D. E., & Leitenberg, H. (1987). Adolescent sex offenders. *Psychological Bulletin, 101* (3), 417-427.

DiGiorgio - Miller, J. (1994). Clinical techniques in the treatment of juvenile sex offenders. *Journal of Offender Rehabilitation, 21,* 117-126.

Dwyer, S. M. (1997). Treatment outcome study: Seventeen years after sexual offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 9,* 149-160.

Federoff, J. P., Wisner-Carlson, R., Dean, S., & Berlin, F. S. (1992). Medroxy - progesterone acetate in the treatment of parahilic sexual disorders. *Journal of Offender Rehabilitation, 18,* 109-123.

Finkelhor, D. (1984). *Child Sexual Abuse: New Theory and Research.* New York, NY: Free Press.

Fisher, D. (1994). Adult sex offenders: who are they? Why and how they do it? In T. Morrison, M. Erooga & R. C. Beckett (Eds.), *Sexual Offending Against Children: Assessment and Treatment of Male Abusers* (pp. 1-24). New York, NY: Routledge.

Freeman - Longo, R., Bays, L., & Bear, E. (1996 . *Empathy and Compassionate Action: Issues and Exercises.* VT: Safer Society Press.

Furby, L. Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105,* 3-30.

George, W. H., & Marlatt, G. A. (1989). Introduction. In D. R. Laws (Ed.), *Relapse Prevention with Sex Offenders* (pp. 1-31). New York, NY: The Guilford Press.

Gibbens, T. C. N., Soothill, K .L., & Way, C. K. (1981). Sex offenses against young girls: A long term record study. *Psychological Medicine, 11*, 351-357.

Gray, A. S., & Pithers, W. D. (1993). Relapse prevention with sexually aggressive adolescents and children: Expanding treatment and supervision. In H. Barbaree, W. Marshall & S. Hudson (Eds.), *The Juvenile Sex Offender* (pp.289-319). New York, NY: The Guilford Press.

Hall, G. C. (1988). Criminal behaviour as a function of clinical and actuarial variables in a sexual offender population. *Journal of Consulting and Clinical Psychology, 56*, 773-775.

Hall, G. C. (1995). Sex offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, 63 (5), 802-809.

Hall, G. C.. (1996). *Theory Based Assessment, Treatment, and Prevention of Sexual Aggression.* New York: Oxford University Press.

Hall, G. C., & Hirschman, R. (1991). Toward a theory of sexual aggression: A quadripartite model. *Journal of Consulting and Criminal Psychology, 59*(5), 662-669.

Hanson, K. R. (1996). Evaluating the contribution of relapse prevention theory to the treatment of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 8*(3), 201-207.

Hanson, K. R. (1997). How to know what works with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 9* (2), 129-145.

Hanson, K. R., & Harris, A. (1998). *Dynamic Predictors of Sexual Recidivism*. Ottawa, Ontario: Corrections Research Department of the Solicitor General Canada.

Hanson, R. K.., & Bussière, M. T. (1996). *Predictors of Sexual Offender Recidivism: A Meta-analysis (No. 1996-04)*. Ottawa, Ontario: Public Works and Government Services Canada.

Hanson, R. K., & Bussière, M. T. (1996). Sex offender risk predictors: summary of research results. *Forum, 8* (2), 10-12.

Hanson, R. K., Steffy, R., & Gauthier, R. (1992). *Long-Term Follow-up of Child Molesters: Risk Predictors and Treatment Outcome (No. 1992-02)*. Ottawa, Ontario: Correctional Services Canada.

Heinz, J., Ryan, G., and Bengis, S. (1991). The systems response to juvenile sex offenders. In G. D. Ryan & S. L. Lane, *Juvenile Sexual Offending* (pp. 185-198). Lexington, Massachusetts: Lexington Books.

Kahn, T. J. (1990). *Pathways. A Guided Workbook for Youth Beginning Treatment.* Safer Society Press. VT.

Kahn, T. J. (1993). *Pathways: A Guided Workbook for Youth Beginning Treatment.* VT: Safer Society Press.

Kahn, T. J., & LaFond, M. A. (1988). Treatment of the adolescent sexual offender. *Child and Adolescent Social Work*, *5*(2), 135-148.

Knight, R. A., & Prentky, R. A. (1991). Exploring characteristics for classifying juvenile sexual offenders. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), *The Juvenile Sexual Offender*. New York: The Guilford Press.

Knopp, F. H. (1985). *The Youthful Sex Offender: The Rational and Goals of Early Intervention and Treatment*. Orwell, Vermont: The Safer Society Press.

Knopp, F. H, & Lane, S. (1991). Program development. In G. D. Ryan & S. L. Lane, *Juvenile Sexual Offending* (pp. 21-39). Lexington, Massachusetts: Lexington Books.

Lab, S. P., Sheilds, G., & Schondel, C. (1993). Research note: An evaluation of juvenile sexual offender treatment. *Crime and Delinquency, 39*(4), 543-553.

Lakey, J. F. (1994). The profile and treatment of male adolescent sex offenders. *Adolescence, 29* (116), 755-761.

Lane, S. (1991). The sexual abuse cycle. In G. D. Ryan & S. L. Lane, *Juvenile Sexual Offending* (pp. 103-142). Lexington, Massachusetts: Lexington Books.

Laws, D. R. (1988). Introductory comments. *Annals of the New York Academy of Sciences; Human Sexual Aggression: Current Perspectives*, 528, 203-204.

Laws, D. R. (Ed.), (1989). *Relapse Prevention with Sex Offenders*. New York, NY: The Guilford Press.

Lombardo, R., & DiGiorgio - Miller, J. (1989). Concepts and techniques in working with juvenile sex offenders. *Journal of Offender Counselling, Services and Rehabilitation, 13* (1), 39-53.

Loss, P., & Ross, J. (1988). *Risk Assessment / Interviewing Protocol for Adolescent Sex Offenders.* New London, CT: Author.

Maletzky, B. M. (1996). The cognitive / cognitive treatment of the sexual offender: The decline of behaviour therapy. *Sexual Abuse: A Journal of Research and Treatment, 8* (4), 261-265.

Marshall, W. L. (1993). The modification of sexual fantasises: A combined treatment approach to the reduction of deviant sexual behaviour. *Behaviour Research and Therapy, 11,* 557-564.

Marshall, W. L. (1994 b). Treatment effects on denial and minimization in incarcerated sex offenders. *Behaviour Research and Therapy, 32,* 559-564.

Marshall, W. L. (1996). Assessment, treatment, and theorizing about sex offenders. Developments during the past twenty years and future directions. *Criminal Justice and Behaviour, 23*(1), 162-199.

Marshall, W. L., & Barbaree, H. E. (1988). The long term evaluation of a behavioural treatment program for child molesters. *Behaviour Research and Therapy, 26,* 499-511.

Marshall, W. L., & Barbaree, H. E. (1990). Outcome of comprehensive cognitive behavioural treatment programs. In. W. L. Marshall, D. R. Laws, & A. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, theories, and treatment of the offender* (pp. 363-389). New York: Plenum Press.

Marshall, W. L., Hudson, S. M., & Ward, T. (1992). Sexual deviance. In P. H. Wilson (Ed.), *Principles and Practice of Relapse Prevention* (pp. 235-254). New York: Guilford.

Marshall, W. L., & McKnight, R. D. (1975). An integrated treatment program for sexual offenders. *Canadian Psychiatric Association Journal, 20,* 133-138.

Marshall, W. L . & Pithers, W. D. (1994). A reconsideration of treatment outcome with sex offenders. *Criminal Justice and Behaviour, 21* (1), 10-27.

Marshall, W. L., & Williams, S. (1975). A behavioural approach to the modification of rape. *Quarterly Bulletin of the British Association for Behavioural Psychotherapy, 4*, 78.

Matthews, F. (1997). The adolescent sex offender filed in Canada: old problems, current issues, and emerging controversies. *Journal of Child and Youth Care, 11*(1), 55-62.

Meyer, W. J., Cole, C. & Emory, E., (1992). Depo provera treatment for sex offending Behaviour: An evaluation of outcome. *Bulletin of the American Academy of Psychiatry and the Law, 20*, 249-259.

Motiuk, L., & Belcourt, R. (1996). Profiling the Canadian federal sex offender population. *Forum, 8 (2)*, 3-7.

Motiuk, L. L., & Brown S. L. (1996). *Factors Related to Recidivism Among Released Federal Sex Offenders.* Ottawa, Ontario: Research Division, Correctional Service Canada.

Nicholaichuk, T. P. (1996). Sex offender treatment priority: An illustration of the risk / need principle. *Forum, 8* (2), 30-32.

Norusis, Marija, J. (1998). *SPSS for Windows: Release 9.0.* Chicago, Illinois: SPSS Inc.

Perry, G. P., & Orchard, J. (1992). *Assessment and Treatment of Adolescent Sex Offenders.* Sarasota, Florida: Professional Resource Press.

Pithers, W. D., Kashima, K. M., Cumming, G. F., Beal, L. S. & Buell, M.M. (1988). Relapse prevention of sexual aggression. *Annals of the New York Academy of Sciences: Human Sexual Aggression: Current Perspectives, 528*, 244-260.

Pithers, W. D, & Gray, A. S. (1996). Utility of relapse prevention in treatment of sexual abusers. *Sexual Abuse: A Journal of Research and Treatment*, 8 (3), 223-230.

Prentky, R. A., & Knight, R. A. (1993). Age of onset of sexual assault: Criminal and life history correlates. In G. Hall, R. Hirschman, J. Graham & M. Laragoza (Eds.), *Sexual Aggression: Issues in Etiology, Assessment and Treatment* (pp.43-62). Washington, DC: Taylor and Francis.

Proulx, J. Granger, L., Ouiment, M., Mekibben, A., Perreault, C., & St. Yves, M. (1996). Improving prediction of sex offender recidivism: A proposed study. *Forum, 8*(2), 13-15.

Proulx, J., Pellerin, B., Paradis, Y., McKibben, A., Aubut, J., & Ouimet, M. (1997). Static and dynamic predictors of recidivism in sexual aggressors. *Sexual Abuse: A Journal of Research and Treatment, 9* (1), 7-27.

Quinsey, V. (1996). Assessment, management and treatment of sex offenders. In Correctional Service of Canada, *Towards a National Strategy: A Conference on Intervention with Sex Offenders* (pp. 20-24). Ottawa, Ontario: Author.

Quinsey, V. L., Harris, G. T., Rice, M. E., & Lalumiere, M. L. (1993). Assessing treatment efficacy in outcome studies of sex offenders. *Journal of interpersonal Violence, 8*, 512-523.

Reid - White, B. (1997). *Healthy Lifestyles. Group Treatment for Adolescent Sex Offenders.* Whitbourne, Newfoundland: Newfoundland and Labrador Youth Centre, Department of Justice.

Richardson, J., Loss, P., & Ross, J.E. (1988). *Psycho-educational curriculum for Adolescent Sex Offenders.* New London, CT: Author.

Rodiques, G. P., & Ouellet, J. (Eds.). (1996). *Pocket Criminal Code: 1997.* Toronto, Ontario: Carswell Thomson Professional Publishing.

Ross, J. & Loss, P. (1991). Assessment of the juvenile sex offender. In G. D. Ryan & S. L. Lane (Eds.), *Juvenile Sexual Offending* (pp. 199-252). Lexington, Massachusetts: Lexington Books.

Ryan, G. (1991). Juvenile sex offenders: Defining the population. In G. D. Ryan & S. L. Lane, *Juvenile Sexual Offending* (pp.4-8). Lexington, Massachusetts: Lexington Books.

Ryan, G. D., & Lane, S. L. (1991). *Juvenile Sexual Offending*. Lexington, Massachusetts: Lexington Books.

Ryerse, C. M. (1996). *National Inventory of Treatment Programs for Child Sexual Abuse Offenders: 1996*. Ottawa, Ontario: Minister of Public Works and Government Services Canada 1996.

Shields, I. W., & Jordan, S. A. (1995). Young sex offenders: A comparison with a control group of non-sex offenders. *Forum 7* (1), 17-19.

Sipe, R., Jensen, E. C., & Everett, R. S. (1998). Adolescent sexual offenders grown up. *Criminal Justice and Behaviour, 25* (1), 109-124.

Smith, W. R., & Monastersky, C. (1986). Assessing juvenile sexual offenders risk for re-offending. *Criminal Justice and Behaviour, 13*(2), 115-140.

Steen, C. (1993). *The Relapse Prevention Workbook for Youth in Treatment.* VT: Safer Society Press.

Stenson, P., & Anderson, C. (1987). Treating juvenile sex offenders and preventing the cycle of abuse. *Journal of Child Care, 3* (2), 91-101.

Stops, M., & Mays, L. G. (1991). Treating adolescent sex offenders in a multi cultural community setting. *Journal of Offender Rehabilitation, 17* (112), 87-103.

Thomas, J. (1991). The adolescent sex offender's family in treatment. In G. D. Ryan & S. L. Lane (Eds.), *Juvenile Sexual Offending: Causes, Consequences and Corrections.* (Pp. 333-376). Lexington, Massachusetts: Lexington Books.

Way, I. F. & Balthazor, T. J. (1993). *A Manual for Structured Group Treatment with Adolescent Sexual Offenders.* Indiana: Jalice Publishers.

Wells, M. (1990). *Canada's Law on Child Sexual Abuse: A Handbook.* Ottawa, Ontario: Department of Justice Canada.

Williams, S. M.(1996). A national strategy for managing sex offenders. *Forum, 8* (2), 33-35.

Appendix A

Department of Justice Permission Letter

GOVERNMENT OF
NEWFOUNDLAND AND LABRADOR

Department of Justice
Newfoundland and Labrador Youth Centre

98-02-20

Sheila Bryne
PO Box 40
Whitbourne
NF

Dear Sheila

I write at this time on behalf of the Administration of the Newfoundland and Labrador Youth Centre to advise you that we will provide you with access to facility data . both statistical and program information , and we will also provide.access to client data, in relation to your research relative to programs offered in secure custody. I would however like to remind you that all information in relation to our clients is confidential and identifying information canno be shared with anyone outside of this facility.
In closing I would like to wish you much success and look forward to working with you in th near future.

Rick Langer
Manager of Resident Programs

P.O. Box 40, Whitbourne, Newfoundland, Canada, A0B 3K0
Telephone (709) 759- 2471 Facsimile (709) 759-2611

Appendix B

Royal Canadian Mounted Police

Royal Canadian Mounted Police / Gendarmerie royale du Canada

Commanding Officer / Commandant divisionnaire

P.O. Box 9700
St. John's, Nfld.
A1A 3T5

June 27, 1997

Ms. Shiela Byrne
P.O. Box 20
South Dildo, Nfld.
A0B 1R0

Dear Ms. Byrne:

This is further to your correspondence requesting access to police record information for statistical/research purposes.

I have had an opportunity to review your request and am prepared to grant you access to our RCMP "B" Division police records for purposes of your research into the effectiveness of treatment programs and the recividism of juvenile sexual offenders, under authority of Section 8 of the federal Privacy Act. In accordance with the provisions of the Young Offenders and Privacy Acts, this permission is granted with the following conditions:

1. Your access to RCMP "B" Division police investigative and record information is limited to information dealing with recividism, charge and conviction information for young persons who now are more than 17 years of age.

2. Access will not be provided to any young offender record material held by the RCMP. "B" Division, except in accordance with an Order of a Youth Court as provided under the Young Offenders Act.

3. The RCMP will not be responsible for any discrepancies or inaccuracies that may exist in the information to which you are provided access. Any use of the information is at your own risk.

4. Any further dissemination/publication of information from police investigation material is not permitted, except as may be required for purposes of your research. Disclosure of the names of subject individuals or information which will tend to identify victims will not be permitted except in accordance with signed consent of the subject of the information or with the specific individual permission of this office.

If you agree to comply with these conditions, I am prepared to grant you access to RCMP Investigative files. I ask that you liaise with Corporal Garry Jay or other members of our Criminal Operations Readers staff, in order to arrange this access.

I trust that this is satisfactory and wish you all possible success in your research efforts.

Yours truly,

L.G. Warren, Chief Superintendent
Commanding Officer "B" Division

Appendix C

Ethics Committee Letter of Approval

Memorial
University of Newfoundland

Faculty of Education
Graduate Programmes & Research

August 6, 1998

Ms. Sheila Byrne
P.O. Box 20
South Dildo
Trinity Bay, NF
A0B 1R0

Dear Ms. Byrne:

After reviewing your proposal, the Ethics Review Committee is satisfied that it meets the guidelines of the Faculty and University. We wish you all the best in your research.

Sincerely,

for T. Seifert
Ethics Review Committee

cc Dr. Norm Garlie

St. John's, NF, Canada A1B 3X8 • Tel.: (709) 737-8587/3407 • Fax: (709) 737-4379