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RESEARCH PAPER

Results from a Multi-modal Program Evaluation of a Four Year Statewide Juvenile Sex Offender Treatment and Reentry Program

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Abstract: *The results of the Program Evaluation show the OJJ Statewide Sex Offender Treatment program is exceptionally productive in meeting over 90% of its established performance markers. These markers included successful screening and assessment of risk and psychosocial needs, completion of initial and master treatment plans, establishment of sex offender specific treatment goals with a focus on psycho-educational treatment components, and community reintegration. The Statewide Juvenile Sex Offender Treatment Program effectively produced the cost benefit of fewer juveniles in secure care, with a 42.3% reduction from pre-grant activities to the present. The results of the Program Evaluation showed a reduction of juvenile sex offenders in the system and a reduction of juvenile sex offenders in secure care, with a 27.5% reduction from pre-grant to the present. The sex offender treatment program effectively reduced recidivism rates of juveniles in secure care and community programs. The total recidivism for sexual and non-sexual crimes was 4.1% from 2008-2012; the sexual recidivism rate was 1.6% for the same time duration. The results of the Program Evaluation showed that the secure care treatment program addressed the needs of the higher risk to re-offend juveniles and the community programs addressed the needs of lower risk juveniles, showing a comprehensive method of ensuring public safety. This comprehensive statewide approach is robust in its ability to address the needs of juvenile sex offenders while at the same time keeping the public safe.*

Keywords: *Juvenile Sex Offender, Program Evaluation, Recidivism, Treatment, Reentry*

Juvenile sex offenders are one clinical population that remains underrepresented in juvenile justice reentry literature. The problem of juvenile sexual offending is well-documented. Adolescents (ages 12-18) commit approximately 20% of rapes and anywhere from 20-50% of child sexual abuse cases in the United States each year (Hart-Kerkhoffs, Doreleijers, Jansen, van Wijk, & Bullens, 2009). Trends in rates of juvenile sexual offense arrests as well as recidivism over the last 10 years have shown little decline (Keogh, 2012). As the number of juvenile sex offenses continues to rise, the tangible and intangible costs to victims, communities, child welfare systems, educational systems and private and state correctional facilities will also grow (Gibson & Vandiver, 2008). Accordingly, there is a need to include extensive program evaluations based on various approaches to juvenile sex offending treatment and reentry programs in order to continue meeting the needs of communities, victims, families, and the youth themselves.

Best practices for juvenile sex offender programs aim to maximize the juvenile's family involvement and reentry and make more connections to neighborhoods, friends and culture while implementing teaching, modeling, and mentoring strategies toward successful reintegration (Keogh, 2012). One significant challenge faced within the juvenile sex offender treatment community is the integration of services across treatment providers, especially related to transitional and reentry planning. Typically, youth who commit sexual offenses are charged, adjudicated and assigned to a level of treatment commensurate with type of offense as well as risk of reoffending. Levels of care normally progress from less restrictive environments such as community outpatient clinic services, to traditional and treatment foster care, to more restrictive environments such as

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residential group care, acute psychiatric services, and finally secure care within a juvenile corrections environment (Underwood et al., 2006). At all stages of treatment, consistency in provider training, program implementation, psychological and risk assessment, as well as program discharge are common challenges. Additionally, the multi-faceted procedures required to ensure positive reentry and youth community reengagement continues to be an important treatment focus. Through formal program evaluation, many of these challenges can be measured and addressed.

The Sex Offender Treatment Model

For the State of Louisiana, these and additional concerns lead to a multi-system shift in delivering services to adjudicated juvenile sex offenders. It was evident that the previous system for legally supervising and managing juvenile sex offenders was disconnected and lacked the rigor and coordination needed to effectively meet the needs of juvenile sex offenders, their families and the community. Effective community reentry and transitioning of juveniles from secure care to community-based treatment was needed. To ensure that juveniles received the appropriate treatment and that secure care was reserved for youths with the highest risk needs, the assessment of risk and treatment needs of juveniles would have to be standardized. Conversely, community-based programs, which would allow for increased family involvement and better management of reintegration services, would need to be primarily reserved for juveniles with the lowest risk. This would ensure that the treatment needs of juvenile sex offenders were met in multiple sites including community-based specialized non-secure residential and outpatient services. Finally, a focus on programming and treatment across reentry phases was also necessary. In particular, a focus on psycho-education was needed across all phases of treatment. However, for those youth reentering the community, this education would increase the likelihood of a seamless transition. The Louisiana Office of Juvenile Justice (JOJJ) received a grant from the Office of Juvenile Justice Delinquency Prevention (OJJDP) in 2008 with the implementation of the grant in 2009 to address these concerns. The Office of Juvenile Justice defined four major goals of the supported program:

1. Reduction in the number of low and moderaterisk sex offenders in the Office of Juvenile Justice's (OJJ) secure care facilities by developing in each of the six service areas of the state a model of community based residential and re-entry programming (outpatient clinics) for juvenile sex offenders.

2. Increased residential alternatives to secure care for juvenile who require out of home placement.

3. Reduction in the average length of stay for juvenile sex offenders placed in OJJ's secure care intensive track program (dorm-based programs).

4. Promotion of statewide institutional and community practitioner adherence to evidenced-based practice models, including a focus on psycho-educational components.

5. A specific focus on the four phases of reentry with increased communication across treatment providers, probation/parole, district attorneys, judges, and schools.

Because community treatment providers and juvenile justice administrators play a significant role in coordinating care in the provision of sex offender placement and treatment for these juveniles, the OJJ developed a comprehensive statewide system. This new system would address the needs of juvenile sex offenders including those juveniles in secure care, community-based residential treatment facilities and community-based outpatient treatment clinics. This statewide system also standardized initial and ongoing assessment and treatment. The continuum of care for adjudicated sex offenders in Louisiana focuses on reducing recidivism among adjudicated juvenile sex offenders (secure care and non-secure care community programs) and increasing safety within Louisiana's juvenile corrections facilities, residential programs, neighborhoods, towns and cities.

A Focus on Reentry

The OJJ maintains a "solutions-centered" reentry model which is intended to identify reentry needs from the time of adjudication, implementing specific plans as early as possible (Melancon & Graham, 2012). The overarching goal of the reentry model for OJJ is to help youths returning to the community to avoid many of the situations that resulted in their initial arrest and detainment. The term engagement is often utilized as a predictor of successful transition. An "engaged" youth is one who is attending school, vocational training or working as well as engaging in prosocial behaviors in their community. Youth disengagement is associated with increased recidivism, dropping out of school, mental health issues, and substance abuse (Mathur & Clark, 2014). While part of the juvenile justice system, a

youth will be in one of various phases aimed at ultimate reengagement with the community. For example, in phase one, a youth enters a secure care environment. At this time extensive assessment and evaluation are conducted for treatment and planning. In this phase, part of the focus is on identifying possible community resources to meet the offender's needs upon reentry, no matter the length of time the youth may remain in care. Phase two involves education, treatment, and other individualized services while in secure care (Melancon & Graham). Despite an intense focus on rehabilitation, this phase is also important in that community resources and partners continue to be identified for reentry. The current OJJ program evaluation focused primarily on phase two coordination of treatment and other resources with emphasis on community reentry. However, the focus on community-based treatment services continues to stress the importance of reentry for OJJ. With a focus on reentry, it is hoped that recidivism rates would decrease and the coordination of services would be improved.

Integrated Treatment

One of the primary components of the comprehensive statewide treatment program is the implementation of a best practices treatment protocol across all sites and providers. As cited in Underwood et al. (in press), the treatment literature indicates that cognitive- behavioral theoretical models are most effective with juveniles involved in the juvenile justice system, including sex offenders. Cognitive-behavioral therapies stress the importance of cognitive processes as determinants of behavior. Cognitive-behavioral therapy maintains that behavior and emotions result from one's appraisal of the situation, and because appraisal is influenced by beliefs, assumptions, images, and self-talk, these cognitions become the targets of change. The model of care utilized in the statewide sex offender treatment program utilizes three basic processes for change: 1) the juvenile's behaviors and reactions to these behaviors; 2) the juvenile's internal dialogue (i.e., what he says to himself before, during, and following the behavior) and; 3) the juvenile's cognitive structures (beliefs) that give rise to internal dialogue (Meichenbaum, 1977). As such, the theoretical and treatment model is primarily cognitive-behavioral treatment incorporating multiple interventions. The program's value lies in the development of empirically based, multi-dimensional, causal models of mental illness, delinquent and aggressive behaviors (Bourdin, 1999).

Treatment Focus: Psycho-Education

For the state of Louisiana, a specialization in the treatment of juvenile sex offenders was identified as particularly salient. Prior to the creation of the new program, consistency of treatment delivery specific to sexual offending behaviors was somewhat sporadic. In developing an integrated treatment approach, a psycho-educational component was specifically introduced across all treatment providers. Within the mental health literature, psycho-educational approaches have several purposes, including providing factual information about behaviors associated with disorders. The main intent is to increase knowledge related to the problem (Becker, 1998). For juvenile sex offenders, a primary psycho-educational component that has shown positive outcomes in the literature is information provided specifically about the abuse cycle, including many of the individual element that contribute to each offender's risk (Prentky, Harris, Frizzell, & Righthand, 2000). Psycho-education regarding the abuse cycle, including historical, situational, cognitive, affective, and behavioral elements was introduced into the integrated treatment protocol to ensure that each offender was aware of their own risk factors and the operation of the abuse cycle in their own individual lives.

Louisiana's statewide treatment program is designed to identify and respond to the challenging needs of juvenile sex offenders. While recognizing the dearth of empirical and evidence-based practices for juvenile sex offenders at a statewide level, this program uses cognitive-behavioral and behavioral approaches, case management, psycho-education, pharmacological and skill-based methodologies as contributing treatment components. Sex offender treatment in this system refers to the provision of culturally and developmentally appropriate assessments, diagnoses, treatment planning, on-going treatment interventions and reintegration services. Within this context, the actual service delivery consists of individual, group, family, psychiatric, educational, crisis intervention, and case management services. Because juvenile sex offenders' needs are addressed in three different placement systems along the continuum of care (i.e., secure care, residential, and community-based outpatient programs), Louisiana's empirically-supported sex offender treatment program is implemented in all treatment settings. However, based on the risk and needs of the juvenile, the dosage of treatment varies per treatment site.

Purpose of the Program Evaluation

As a means to measure Louisiana's progress toward important goals, OJJ recommended a program evaluation be conducted. The purpose of the program evaluation was to assess the following six overarching

goals:

1. Ninety-five percent of community providers and probation officers will successfully complete sex offender specific trainings.

2. Six regional treatment programs would be developed, resulting in one per service region.

3. Six community re-entry (step-down) programs would be developed, resulting in one per service region.

4. Six family intervention programs would be developed, resulting in one per service region to improve reentry services.

5. Development of program materials covering the following topics: training curriculum, assessment protocol, treatment protocol including psycho-educational components, probation/parole supervision guidelines.

6. Ninety percent of providers substantially adhering to the OJJ established practice model.

Each of these goals was categorized into three broad areas: direct service delivery, systems improvement, and research and development. Each of these areas contained specific evaluation goals to be accomplished and measured through a series of program evaluation methodologies, utilizing quantitative and qualitative strategies. Appendix A summarizes evaluation activities that quantify the above stated goals.

Program Evaluation Methodology

The current program evaluation relies upon a multi-modal methodology for collecting, analyzing, and using information to answer critical questions about the sex offender treatment program. For each program evaluation activity, an outcome measure was assigned to capture essential information. Table 1 summarizes methodology utilized in the evaluation.

Participants

Participants were all persons involved with OJJ programs including secure care facilities, residential programs, and outpatient treatment clinics. Participants included not only juveniles, but their parents/guardians, providers, staff, probation officers, judges, and other court personnel. Participants were organized along the following broad categories:

1. Administrators (facility directors, assistant directors, regional managers, judges)

2. Treatment Providers (mental health providers, case managers, group leaders, probation officers)

3. Direct Supervision personnel (juvenile justice staff, residential counselors)

4. Juveniles (secure care, residential treatment and outpatient)

5. Families and other caretakers

The OJJ juveniles included males ranging in age from 12 to 21 years of age. Juvenile sex offenders classified by race show an equal distribution of African-Americans (45%) and Caucasians (51%). The Native American and Hispanic populations were both near 1%. The most frequent age of juvenile sex offenders was 14-15. Table 2 lists the number of juveniles in care during the program.

Table 2: Juvenile Sex Offenders from 2008-2012

2008	142
2009	118
2010	154
2011	117
2012	103

Each participant was given an opportunity to take part in the program evaluation process by providing written and oral feedback to several surveys regarding the Louisiana Juvenile Sex Offender treatment program. Participants had the right to refuse participation in the evaluation process at any time.

Instrumentation

Nine measures were utilized for information gathering for this program evaluation. These quantifiable and qualitative measures included interviews (structured), observations (audit and file reviews), and self-report measures (social climate and satisfaction surveys). Some of these measures relied upon a true-false format or Likert format, while others relied on forced response methods. Table 3 provides a summary of instruments utilized. Descriptions of each instrument follow.

Structured Interviews. The program evaluators traveled to all of the sites identified for this evaluation.

Table 1: Multi-Modal Program Evaluation Methodology

Program Evaluation Multi-Modal Methodology
1. Interviews with juveniles in secure & non secure community programs
2. Interviews with program staff in secure & non secure community programs
3. Consultation with administrators of OJJ and community providers
4. Focused meetings with community providers
5. Review treatment plans in secure and non-secure community programs
6. Review psychosexual risk assessments in secure care & non secure programs
7. Conduct environmental tours of secure and non-secure care programs
8. Observe group facilitation interventions by staff members
9. Administer satisfaction surveys to staff and family members
10. Observe assessment process and other treatment activities
11. Conduct interviews with community providers
12. Review training records and other program development activities
13. Assess systems function including recidivism rates and reduction of juvenile sex offenders in secure care programs

Table 3: Program Evaluation Instrumentation

Program Evaluation Instrumentation
1. Structured Interview for Administrators/Managers/Judges
2. Structured Interview for Clinical Providers
3. Structured Interview for Direct Supervision Staff
4. Structured Interview for Youth
5. Satisfaction Survey – Staff
6. Satisfaction Survey-Family
7. Program Audit & File Review
8. Ward Atmosphere Scale (WAS)-Residential Staff
9. Ward Atmosphere Scale (WAS)-Residential Youth
10. Juvenile Sex Offender Assessment Protocol- II (JSOAP-II)- Residential Youth

While onsite, in-person unstructured interviews were conducted, and all sites were administered structured interviews.

Satisfaction Surveys. Program evaluators utilized three separate 10-item surveys to assess the staff and family satisfaction with the Louisiana's Sex Offender program. Responses to prompts are rated on a Likert scale ranging from "Very Satisfied" to "Very Dissat-

isfied."

Ward Atmosphere Scale (WAS). The WAS, an instrument developed by Rudolf Moos (1996), was utilized by the program evaluators to assess the climate within secure care and residential care facilities. This 100-item questionnaire is completed by all residential programs including secure care and residential care. The WAS is composed of 10 subscales that measure the actual, preferred, and expected treatment environments of hospital-based psychiatric programs. The WAS assesses three underlying sets of dimensions. The Involvement, Support, and Spontaneity subscales measure relationship dimensions. The Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression subscales tap personal growth dimensions. Order and Organization, Program Clarity, and Staff Control subscales assess system maintenance dimensi ons.

Juvenile Sex Offender Assessment Protocol – 2 (J-SOAP-2; Prentky, Harris, Frizzell, & Righthand, 2000). The J-SOAP-2 is an evidenced based assessment of risk factors that have been linked to both sexual and violent offending in juveniles. The measure is designed for use with males 12-18 years of age. No cutoff scores have been provided for risk level and the J-SOAP-2 is recommended to be used as part of a more comprehensive assessment and not in isolation (Martinez, Flores, & Rosenfeld, 2007). The J-SOAP-2 has four scales that include measures of sexual drive/preoccupation, impulsive/antisocial behavior, intervention variables such as treatment motivation, and community stability/adjustment. Studies involving the J-SOAP-2 indicate moderate to high interrater reliability ranging from .75 to .91, as well as internal consistency alphas from .68 to .85.

Observational Reviews. There were three methods of observation utilized outside of direct interviews:

1. On-site Visits: The program evaluator conducted on-site visits on four separate trips from December 2012 – March 2013. The program evaluator visited all of the secure care facilities, all of the residential treatment facilities and outpatient clinics and all of the regional probation officers.

2.Audit & File Reviews: The program evaluator reviewed treatment files of juveniles in the secure care, residential and outpatient programs. The file audit consisted of a 31-question structured form that measured the degree of the file's compliance with general programmatic best-practices for sex offender programs (e.g., assessment scores, risk level, treatment plans, sex offender specific goals, transition plans).

3.OJJ Outcome Data: OJJ staff provided statistical information from their Youth-Database regarding their outcomes: recidivism rates and youth demographics.

Ethical Considerations & Confidentiality of Data

This evaluation followed the ethical guidelines provided by the American Evaluation Association Guiding Principles for Evaluators (2004), including but not limited to conducting a systematic, accurate and credible inquiry of archived data. In addition, the design was aimed at providing a competent program evaluation to all stakeholders touched by this evaluation, and to ensuring respect, honesty, and integrity of the evaluation process. The evaluator analyzed data about juveniles and adults that is sensitive in nature. Confidentiality was assured by the evaluator in a formal agreement, executed by both parties, to guarantee that information obtained for evaluative purposes was placed in strict confidence. To ensure the confidentiality of institutionalized youth, a formal confidentially agreement between the program evaluator and JOJJ was executed. Special attention was given to the security of all de-identified data files for confidentiality of all participants.

Results

The results of the program evaluation show the OJJ Statewide Sex Offender Treatment program is exceptionally productive, meeting over 90% of its established performance markers. A variety of statistical analyses were conducted using the data from the Louisiana Sexual Problem Behavior Program Evaluation. The primary findings of the program evaluation center on the areas of direct service delivery and systems improvement. Within direct service delivery, there are several noteworthy findings based on the evaluation. For example, 100% of behavioral health providers, staff, and community partners received training on the juvenile sex offender treatment protocol at the beginning of the program, including psycho-educational protocol related to the abuse cycle and community reentry. Additional trainings were provided as needed. With regards to treatment planning, there were two goals. The first involved completed treatment plans. Ninety- five percent of youth in the program had treatment plans completed. The second goal focused on content of treatment plans, specifically sex offender elements. Ninety six percent of treatment plans contained sex offender specific goals, progress markers, therapeutic notes about progress, and relapse prevention skills. Additionally, suc-

cessful completion of treatment program phases was also reviewed. For juveniles in secure care, 98% completed each of the three treatment phases appropriately. For juveniles in community programs, 90% completed the phases as prescribed by the treatment model.

Another focus of service delivery included rates of recidivism following reentry, both sexual and non-sexual. Typically, a rate ranging from 3-15% is considered average for sexual recidivism (Caldwell & Dickinson, 2009). Within the program, there were approximately 13 juveniles who met some portion of the criteria for recidivism. Of the 13 juveniles, five were for sexual crimes and 8 were for non-sexual crimes. Some of the crimes included indecent exposure, battery of a school teacher, burglary, simple battery, armed robbery, aggravated battery, failure to register, criminal damages, and murder. Of the 312 total juveniles, the total recidivism rate was 4.1%. However, sexual recidivism was 1.6%, well below norms established in the literature.

There were several goals related to the risk of reoffending based on the JSOAP-2. For example, a goal was set that all youth entering treatment would receive the JSOAP-2 to better assess psychosexual risk and for assignment to appropriate level of care. One hundred percent of youth entering the system received an initial assessment. Treatment progress was also measured using the JSOAP-2, with a goal for a decrease in dynamic risk scores during treatment. Notable changes were seen. A dependent samples t-test was conducted on pre and posttest JSOAP-2 data. The results indicated that the dynamic subscales decreased from pretest to posttest. The changes were statistically significant for both the intervention subscale ($t(14)=3.22$, $p=.006$) and the community stability subscale ($t(14)=3.20$, $p=.007$). Additionally, those in the moderate risk to reoffend category saw the most decrease in scores across subscales. Proper use of the JSOAP-2 was also a key factor in another program goal relating to reduction in the number of juveniles in secure care settings. In 2008, there were approximately 142 sexual offenders in the juvenile justice system. By 2012, there were 103 juvenile sex offenders in the state's custody, a reduction of 27.5%. Of the 103 offenders currently in the system, there were 41 in secure care, compared to 77 in 2008. The represents a reduction of 42.3% and successfully supports the goal of having more offenders remain with their families and in community based treatment programs when possible.

In considering outcomes for systems improvement goals, several findings are of particular interest. Community-based residential programs saw an increase in funding and availability of beds while implementing the same evidenced-based treatment protocol being used in secure care. In fact, during the life of the grant, approximately 187 juveniles were served in the community who would otherwise have been admitted to secure care. Further, community provider perceptions of effectiveness, quality, and efficiency of the treatment program were also examined through semi-structured interviews, which demonstrated approval of the program and stated goals. Additional interviews with staff, families and youth provided similar results.

Generally, staff surveys were in the "above average" range, suggesting satisfaction with the program's goals, expectations, training, techniques, interventions, and transition planning. Of particular importance was approval of the psycho-educational aspects of the program, which was highly endorsed by providers and staff. Family satisfaction surveys were significantly higher than staff members, with a focus on effective transitions of youth from most restrictive to least restrictive as an identified strength. Table 4 summarizes the comparison between staff and family member satisfaction surveys.

The Ward Atmosphere Scale (WAS) was also utilized as an outcome measure for staff, youth, and their families. The subscale scores for the WAS were converted into T-scores. These T-scores were analyzed using inferential statistics, specifically MANOVA and ANOVA, to determine if statistically significant differences existed between the eight treatment sites. Several findings are important to note. Among the eight treatment sites, four subscales emerged as statistically significant. These include Support ($F(2, 144) = 2.237$, $p=.035$, $r^2=.105$), Spontaneity ($F(2, 144) = 2.788$, $p=.010$, $r^2=.127$), Personal Problems ($F(2, 144) = 2.544$, $p=.017$, $r^2= .117$), and Order and Organization ($F(2, 144) = 2.933$, $p=.007$, $r^2=.133$). These results provide additional information about the program and how important support and other relational variables are perceived by staff and residents. These are also main foci of the treatment program and support the program's success as a whole.

Program Recommendations

Based on outcomes from the program evaluation, comprehensive program recommendations were made to the state of Louisiana and future goals were established. Table 5 summarizes these findings.

Discussion and Lessons Learned

One of the primary purposes of program evaluation is to make judgments or decisions about the usefulness of a model or approach (Holden & Zimmerman, 2009).

Table 4: Family and Staff Satisfaction Survey Comparison

Dependent Variable	(I) Name	(J) Name	Mean Difference (I-J)	Sig.
Youth S/O Tx	Family	Staff	.493*	.002
	Staff	Family	-.493*	.002
S/O Tx Program	Family	Staff	.458*	.004
	Staff	Family	-.458*	.004
Family Sessions	Family	Staff	.694*	.000
	Staff	Family	-.694*	.000
Length of Time Youth in Tx	Family	Staff	.465*	.003
	Staff	Family	-.465*	.003
Skills Youth Learned	Family	Staff	.521*	.000
	Staff	Family	-.521*	.000
Thrpst and Case Mgr's Knowledge regarding Tx of Youth S/O	Family	Staff	.556*	.000
	Staff	Family	-.556*	.000
Getting Answers to Questions about Youth's Progress	Family	Staff	.799*	.000
	Staff	Family	-.799*	.000
Manner in which Thrpst or Case Mgr Discussed Youth's Progress	Family	Staff	.493*	.004
	Staff	Family	-.493*	.004
Effort Made for Early Release after Youth Completed Tx Satisfactorily	Family	Staff	.236	.129
	Staff	Family	-.236	.129

*The mean difference is significant at the .05 level

Louisiana's approach to streamlining and improving the delivery of services and treatment to juvenile sex offenders and their families appears to have made a successful beginning. Ongoing evaluation will be needed to continue assessing program goals. This program evaluation was designed specifically for the state of Louisiana but has a wide array of practical implications for juvenile justice systems, program evaluators, and treatment providers elsewhere.

Treatment Providers

In considering treatment programs for juvenile sex offenders, there are several important take away messages from the current program evaluation. The first is the importance of utilizing an evidenced-based treatment model to meet program objectives, such as reducing recidivism and improving reentry and community transition plans. Within the juvenile justice system, evidenced-based treatments are defined as "a body of knowledge, also obtained through the scientific method, on the impact of specific practices on targeted outcomes for youth and their families" (Underwood et al., 2006, p. 287). According to the National Institute of Mental Health (NIMH), evidenced-based practices include:

1. A minimum of two control group studies or a large series of single-case studies.

2. At least two researchers

3.Treatment manual utilization

4.Training for therapists with written protocols

5.Adequate clinical samples

6.Significant results from outcome tests

7.Clinical reviews of program functioning and symptom outcomes

8.Reports on long term outcomes following treatment completion

9. Two or more studies that demonstrate treatment superiority over medication, placebo, or other established treatment protocols (Underwood et al., 2006).

In working with juvenile populations, evidenced-based treatments utilize several outcome principles. These principles include assessment of risks and needs, enhancing intrinsic motivation for change, providing objective interventions that are structured, skills training, using positive reinforcements, utilizing community resources for support, and providing measurable feedback through assessment of practices and processes (Underwood et al., 2006).

Additionally, the importance of ensuring that an appropriate risk assessment is conducted at regular in-

Table 5: Overview of Program Evaluation Recommendations

System Improvement Recommendations
1. Revise the Sex Offender Treatment manual and curriculum to include complete manualized curriculum on a compact disk with all assignments, lesson plans, and corresponding documentation.
2. Enhance and systematize training with all providers to occur every year and include tracking of participants and training contents.
3. Establish Quality Assurance (QA) and Quality Improvement (QI) protocols regarding adherence to the program fidelity that is conducted with regular audits.
4. Establish a dedicated Management Information System (MIS) tailored to capture critical information regarding recidivism and probation/parole violations.
5. Create a Policy and Procedure manual to assist with the standardization of the Sex Offender Treatment program.
6. Adjust new service contracts to include language in which the service provider is responsible for the collection and submission of raw assessment data, its summarization, and a general interpretation of JSOAP-2 and other assessment data
Direct Services Recommendations
1. Consider identifying a community-based trainer to better ensure training needs are met and allow for additional case conceptualizations and trouble-shooting for reentry service providers as needed.
2. Establish written documentation and other forms of communication with direct care staff such as Juvenile Justice Staff (JJS) to better ensure JSOAP-2 results are utilized in juvenile's treatment.
3. Promote the use of common assessment and treatment language centered on JSOAP-2 and the JUMP program, especially in regards to treatment and aftercare planning activities around risk levels.
Research & Development Recommendations
1. Establish collaborative relationship with interested service providers to participate in ongoing research and publications (scholarly and general works).
2. Utilize new databases and data collection protocols to share positive outcomes with service providers, families, local government agencies, and the correctional community at large.
3. Consider conducting program evaluations on an annual basis to identify critical themes and patterns.
4. Develop an Action Plan, outlining key recommendations included in this report which includes the action, monitoring information, progress to date and the responsible individual.

tervals throughout reentry phases of treatment is also imperative in monitoring treatment outcomes. Risk assessments with juvenile sex offenders specifically examine the risk of recidivism based on empirically supported factors related to reoffending. The state of Louisiana selected the JSOAP-2, which has demonstrated good clinical utility in the literature. However, there are other widely used risk assessment tools that could also be utilized. For example, the Juvenile Sexual Offense Recidivism Risk Assessment Tool – II (J-SORRAT-II; Epperson, Ralston, Fowers, & DeWitt, 2005) is based on a review of the juvenile's criminal record related to the charged offense. It shows high rates of reliability between raters (r = .89 or higher; Hempel et al., 2013). The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling, 2002) is another tool that can be used to assess youth aged 12-18 years of age. The ERASOR provides a risk estimate based on short-term factors, and cannot predict risk for more than one year. While there are many instruments available, utilizing a risk assessment at intake and then again throughout the treatment process is recommended for treatment providers seeking to evaluate their programs.

Treatment plan completion as well as goals integrating sex offender specific behaviors is another important treatment aspect demonstrated in the current evaluation. Treatment plans offer a systematic map of treatment goals and how they will be measured. The plans are designed to be created by both the therapist and, in this case, the juvenile. Including additional family or support individuals is also recommended (Adams & Grieder, 2005). Although there is no standard template, a quality treatment plan will include the following elements: problem definition, broad goals that address the target problem, measurable objectives that provide steps toward goals, and specific interventions (Jongsma, Peterson, & Bruce, 2014). For the juvenile sex offender population, it is particularly important that goals and objectives be centered on the desired treatment outcomes. Some of the desired outcomes for the program in this evaluation included an increased ability to accept responsibility for specific sexual as well as other offenses; the development of internal motivation for change, building an understanding of risk factors and applying risk management strategies; the ability to empathize, demonstrating remorse and guilt; the ability to analyze cognitive distortions related to sexual behaviors; and building skills to maintain quality peer relationships (Underwood et al., 2006). Introducing a psycho-educational component to all treatment phases was also highly valued by treatment providers and staff and provided important information for juvenile sex offenders as they determined goals and objectives with their treatment providers, increasing the utility of the treatment planning process. In order for treatment plans to be useable and effective, not only individual goals but also program specific goals for juvenile sex offenders should be included. This ensures that the youth, providers, and family are aware of what and how specific needs are being addressed.

In order to effectively implement an evidenced-based treatment program, special attention must be paid to implementation. Training was one major goal of the current evaluation. The evidenced-based treatment protocol utilized by the state of Louisiana contains a treatment manual and specific curriculum to be utilized throughout treatment. Clinicians need to be familiar with and trained in the protocol for optimal benefit. Training typically contains two components. The first is didactic, which involves workshops and written materials and is often conducted face-to-face. The second is competence training, which involves some type of supervision or coaching of clinicians utilizing the protocol (McHugh & Barlow, 2010). In the current program evaluation, initial trainings were conducted with 100% of staff. Additionally, follow-up trainings were conducted to build competency. For clinicians treating juvenile sex offenders, the inclusion of appropriate and frequent training is an essential part of ensuring protocol fidelity and improving outcomes. Training was particularly important for community treatment providers involved in reentry. Ensuring that treatment meets the needs of youth and their families is an important step in the reengagement process. A continual focus is needed to ensure that training is occurring in order to reduce the overall risk of recidivism for youth leaving secure care.

Juvenile Justice Systems

Juvenile justice systems can also benefit from the current program evaluation. The main premise of the juvenile system is to provide care and treatment rather than punishment. However, there have been recent movements in the last several decades toward a tougher system. Juvenile sex offenders have long been considered more "criminal" than "wayward," and at adjudication are often institutionalized when other, less restrictive options may be available (Bernard & Kurlychek, 2010). The state of Louisiana recognized this problem and sought to strengthen less restrictive treatment environments as a result. Juvenile justice systems can also benefit from identifying reentry programs at the outset of a youth's stay in the program. Early identification

of reentry services assists in coordinating care upon program discharge. Within the juvenile justice treatment outcome literature, youths often fair better within less restrictive environments and with more family and community involvement (Quayle & Taylor, 2009). Focusing resources on strengthening these programs can improve outcomes for youth, families, and communities.

The role of probation and parole officers continues to be a key part of community reintegration for juvenile sex offenders. Probation and parole officers have the difficult responsibility of providing services to a growing number of youth and their families. These systems must be well-managed and incorporate effective, evidence-based protocols. Having officers who, through education and experience, have acquired the necessary skills to effectively manage juvenile sex offenders and their unique needs is an important piece of a well-managed system (Raymond & Jones, 2006). Through strengthening relationships and training of probation and parole administrators and officers throughout Louisiana, more youth were able to be successfully managed within the community instead of through incarceration or more secure environments. Probation and parole officers play an important role in keeping youth in the least restrictive environments possible. Keeping high quality officers and administrators and providing them with training on evidenced-based models can be effective and less costly than incarceration for lower risk juvenile offenders.

Treatment and Reentry Program Evaluators

When completing a multi-faceted program evaluation, there are many challenges for evaluators. Having a well-organized system of primary evaluator and support staff is a crucial part of successfully evaluating a large program. For this particular evaluation, coordinating at regular intervals with the state of Louisiana's juvenile sexual problem program director and other staff was also necessary. Maintaining a plan of whom to include in the evaluation, how, and when is also an important component. Although some flexibility must be allowed for, the fidelity of the evaluation rests on the methods planned for and utilized. Communicating these important pieces with all individuals, including staff, the juveniles, and their families helps to strengthen the evaluation.

Conclusions

This program evaluation sought to address the changes made by the state of Louisiana to address concerns with treatment and management of juvenile sex offenders. Based on the results, the state of Louisiana's program was over 90% effective in meeting stated goals. Through ongoing evaluation, continued progress will be monitored and challenges addressed. The results of the current evaluation will continue to be utilized by the program to improve service delivery for staff, youth, and their families throughout the treatment and reentry process.

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Appendix A: Overview of Program Evaluation Activities

Program Evaluation Activity #1: Direct Service Delivery
1. Incorporate Mentors and Milieu Manager for intensive institutional Treatment Track in Secure Care
2. Provide Training & Technical Assistance to Secure Care and community-based staff (six regions) legal & mental health professionals, disseminate assessment and treatment protocols, train mentor home providers, probation officers, family intervention specialist
3. Percentage of Youth Completing Psychosexual Risk Assessment
4. Percentage of Treatment Plans Completed
5. Percentage of Treatment Plans with Sex Offender Specific Goals & Objectives
6. Program Effectiveness of Treatment Phase Completion
7. Rates of Sexual and Non-sexual Recidivism
8. Change in Dynamic Risk Scores on the JSOAP-2
9. Number of Probation & Parole Violations
Program Evaluation Activity #2: Systems Improvement
10. Reduction in number of juvenile sex offenders committed to Secure Care and the days in Secure Care
11. Adding Beds and implementing a evidence based model for community-based residential programs
12. Expand evidence based supported sex offender model in six regions (Community Providers) of the state
13. Stakeholders (Community providers) Perception of the effectiveness of the program and quality and efficiency of inter-agency cooperation and collaboration in case management
14. Youth Interviews, Staff Interviews, Stakeholder (Community Providers) Consultations
Program Evaluation Activity #3: Research & Development
15. Develop and disseminate Program Evaluation Research Plan for dissemination and publication to the field via reports and manuscripts

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