A Comparison of Paradigms in the Treatment Programmes of Adolescent Sex Offenders

by

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Abstract

As the number of charges against adolescents for sexual offences increases, with concomitant public concern, there has also been a noted growth in the number of treatment programmes for these offenders. Following from this growth, there has been a proliferation of research and articles on sex offenders, both adult and youth. Since, most of the literature has originated from the United States, there is a need for Canadian research on the topic.

The present research examined four Canadian adolescent sex offender treatment programmes. A comparative analysis was conducted pertaining to the theories underlying the four treatment programmes, the characteristics of the participating adolescents, and recidivism rates yielded by each of the programmes.

All four treatment programmes primarily followed social learning theory (also known as cognitive-behavioural theory) in their operations. This theoretical approach asserts that abnormal behaviour, as with any behaviour, is learned. Treatment components derived from this theoretical perspective include: satiation, cognitive restructuring, victim empathy, sex education, accountability therapy, covert sensitization, and aversive arousal. The four treatment programmes did vary in the particular selection of core components employed, e.g., two of the programmes included narrative therapy as part of the focus, while the other two did not.

Significant differences were found among the four programmes in the repeating of school grades, and in experiencing sexual abuse. The incidence of recidivism varied across treatment programmes. Most of the adolescents who reoffended, committed their first reoffence within the first year, and all of the adolescents who reoffended in the follow-up time frame began to

do so by the end of the second year following release from a treatment programme. Finally, most of the reoffences were for breaches or non-sexual offences, not sexual offences.

The significance of the research lies in its Canadian focus, the unique comparison of four treatment programmes for young sex offenders and the implications the findings have for future policy and programmatic development. It is of special interest in the regard to note the relatively low recidivism rates, as compared to those rates found for offenders more generally.

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Chapter 1 - Introduction

There has been growing interest about the effectiveness of sex offender treatment programmes, primarily as it is applied to adults, but increasingly the focus is shifting to treatment for the adolescent sex offender. The public's concern over the problem of adolescent sex offenders has increased as the number of youth charged and sentenced for sexual assault has grown. In 1984-85, 190 adolescents were sentenced for sexual assault (Statistics Canada, 1990), compared to 962 youths who were sentenced for sexual assault in 1992-93 (Statistics Canada, 1993). Graves, Openshaw, and Adams (1992) state that this growth is attributed to improved methods of reporting, changing beliefs in the teenage exploratory nature of the offences from "they're only teenagers" to "this youth needs help", and the decrease in stigmatization attached to the victim who is sexually assaulted. There has also been a dramatic increase in the number of programmes to deal with adolescent sex offenders. The proliferation of articles describing the numerous programmes across North America is a sure sign of the growing interest in the area. Most of the articles clearly describe the type of programme in operation, but most do not critique the programmes by presenting outcome data on the "success" rate.

Interest for examining the effectiveness of treatment programmes[1] for adolescent sex offenders, specifically in British Columbia, arose after two programmes expressed interest in knowing whether their own programmes were effective and sufficient to meet the needs of the adolescent sex offenders.

[1] Treatment programme will be defined, for the purpose of this research, as the overall programme, including the treatment components, and the theoretical approaches. The treatment components will be defined as the individual parts that make up the programme (i.e., sex education, and cognitive restructuring).

This current research will build on previous research, and will lead to comparisons being made among different treatment programmes in British Columbia. An overall comparison will be drawn as to recidivism rates of the adolescents in the various programmes. There will also be an examination of the theoretical perspectives, and the underlying assumptions, behind each treatment programme. Other areas that will be compared will include demographics, educational and family histories, physical and mental health histories, substance abuse histories, sexual abuse histories, past and present (current) offences, and victim variables.

Most of the research has concluded that between 90-95 % of adolescent sex offenders are male (Alijazireh, 1993; Kahn & Chambers, 1991; and Statistics Canada, 1986). There has also been speculation that male and female sex offenders may have different backgrounds and etiologies (Lombardo & DiGiorgio-Miller, 1988). Therefore, the current research will focus exclusively on male adolescent sex offenders. The definition of sexual assault which will be employed for the purpose of the thesis is the one the courts define and adjudicate the youth offenders as being. In the Criminal Code sexual assault is defined as being "committed in circumstances of a sexual nature such that the sexual integrity of the victim is violated" (Martin's Criminal Code, 1993, p. 454). The sexual nature of the offence is regarded as whether the "sexual or carnal context of the assault is visible to a reasonable observer" (Ibid.). The circumstances examined include the part of the body touched, the situation, any words or gestures accompanying the assault, and use of coercion or power. The sex offences include "sexual conduct which involves coercion, manipulation, abuse of power, or is committed against individuals who are unable to give informed consent" (Alijazireh, 1993). The sex offences can be both acts that include physical contact with the victim and those acts in which

there is no contact between the offender and victim. The most common charges in the Canadian Criminal Justice System for a sexual assault are CC sections 271, 272, 273, 151, 152, 153, 155, 159, and 160 (See Appendix C for definitions of each section).

Hypothesis /problem

A comparison will be made of different treatment programmes of adolescent sex offenders in British Columbia. It is assumed that each treatment programme uses a specific treatment method based on the theory that most closely encapsulates its views on the appropriate treatment for adolescent sex offenders. Basic questions to ask, therefore are: what the theories are behind each of these treatment programmes, that is, are they different from each other; and, if so, in which underlying assumptions?

Each treatment programme may have different admission criteria for entrance. Different admission criteria may lead to treatment of different types of adolescent sex offenders (i.e., with different characteristics). The location of the programmes (two in a rural setting and two in an urban setting) may also lead to the admission of different types of youth. Relevant questions to pose in addressing the basic issues are: "what are the characteristics of the adolescents in the four programmes"; and "are there any differences in the characteristics of the adolescents in the different programmes?"

Another area to examine in the investigation of theoretical appropriateness, will be the outcome data of each programme. In consideration of the different admission criteria, a comparison of the recidivism rates of each programme will help to determine if one treatment programme is more "successful" in stopping the adolescent sex offender from committing

more crimes. Are there any differences in the recidivism rates of the programmes? As will be seen below, recidivism has been used as the historic measure for these youth.

It is expected that the programmes will not differ in recidivism rates, since all four programmes include at least one component of the cognitive-behavioural theory, and techniques, which appears to be a "successful" treatment approach by this type of offender (Ross & Fabiano, 1985). In other words, a "pure" delineation may not be possible because of multi-modal contamination.

Importance of the Research

The majority of the past, and even current research on adolescent sex offenders, has examined the outcomes of single programmes only. Few studies have employed control groups, or even comparison groups which utilize different treatment programmes. The few studies that have compared various programmes (such as, Sapp and Vaughn, 1990) have been conducted in the United States. The few reports written in Canada have been inquiries and all have suggested that further research is needed. Adolescent Sex Offenders: A Needs Study (1987), which summarized the then current status of treatment and its many weaknesses, was complied in the Metropolitan Toronto area. This publication, along with a few others, constitutes the majority of Canadian literature focusing on adolescent sex offenders. Since there is so little Canadian data, more research needs to be conducted into adolescent sex offenders in Canada.

Most of the articles that were written on treatment programmes for adolescent sex offenders in the past only went as far as describing the programme and its methods. There is

very little outcome data to indicate whether the programmes were effective and successful in their goal of stopping sex offences.

Therefore, there is a need to study the theories underlying the treatment programmes, as the theories are the basis for the development of the treatment programmes. Links have not been systematically studied between the theories about sex offences (behaviour) and the type of treatment being used to treat the sex offenders.

Another important reason for this current research is to start the obtainment of data on adolescent sex offenders, so that further research will be possible on various other aspects of sex offenders with these groups.

As stated at the beginning of this thesis, the number of adolescents sentenced for sexual assaults appears to be growing. If this is the case, then research is needed in order to determine how best to stop these adolescents from repeating their crimes. Also, it would be better to understand if there are certain signals -- characteristics or part of their environment that might predict who is at risk for committing sex crimes and how to target these adolescents.

Proposed Chapters

This thesis is composed of six chapters. The second chapter will review and summarize the research on the various characteristics of the offender, victim and the offence. The third chapter will include the overall general theories that have been proposed to explain sex offences. The fourth chapter will focus on the main treatment therapies used in the treatment of adolescent sex offenders, and the outcome data that has been collected on these programmes. The fifth chapter will describe the research methodology and the subjects. The

fifth chapter will also report the results, present the data, and analyse the results. The last chapter will be the summary of the results obtained and their meaning, the limitations of the research, and suggestions for further research.

Chapter 2 - Characteristics

Most of the profiles of adolescent sex offenders have been of adolescents who have participated in treatment programmes or have been incarcerated. These studies have examined numerous characteristics, including; previous abuse, age, race and ethnicity, family background, education, type of crime committed, legal histories, and medical and psychiatric illnesses. These are only a sample of the various characteristics that have been studied. Some of these characteristics have been investigated more thoroughly than others, either due to the convenience of locating them, or because they are thought to be of the most importance in studying adolescent sex offenders. The current research collected information on 12 primary characteristic areas. The prior research on these characteristics will be examined below.

Age

One of the most prominent pieces of information included in adolescent sex offenders' profiles is their age at the time of the offence. Bremer (1992), reported that only a minority of the adolescents were 17 years of age, and that the majority of subjects were between 14 to 16 years of age. Becker, Cunningham-Rathner, and Kaplan (1987), reported a mean age of 15.47 and an age range from 13 to 19 years. A mean age of around 15 years (range of mean ages was 14.5 - 15.87 years) was the most commonly reported age of the adolescent sex offenders (Truscott, 1993; Mathews, 1987; Hunter & Santos, 1990; Kahn & Lafond, 1988; Becker, Cunningham-Rathner, & Kaplan, 1987; Graves, Openshaw, & Adams, 1992; Bremer, 1992; Cotton, 1987; Becker, 1988; Oliver, Nagayama Hall, & Neuhaus, 1993; and Kahn & Chamber, 1991). Three studies found the mean age of adolescent sex offenders to be closer to 14 years (Borduin, Henggeler, Blaske, & Stein, 1990; Smith & Monastersky, 1986; and

Awad, Saunders, Levene, 1984). One further study found the mean age to be above 16 years (16.5 years) at the time of the current offence (Brannon, & Troyer, 1991).

While most of the studies included adolescents between the ages of 12 and 18, others used 13 to 17 year olds (Mazur & Michael, 1992), and still others used 16 to 18 year olds (Hains et al., 1986). The inclusion of subjects in different age ranges may greatly affect the mean age reported in the studies. In a preliminary study by Jackson (1984), it was reported that 24 percent of the offenders where 16 years old at the time of the offence, and over three-quarters of them were 17 years old. This portrays an older adolescent sex offender population, but the treatment programme studied by Jackson (1984), only accepts youths that are 16 and 17 years of age. A mean age of 15 years would be impossible to calculate, and therefore, this study is not comparable to the other studies which included a greater age range.

Ethnicity

Since most of the research of adolescent sex offenders is conducted in the United States there has been an emphasis on the division between Caucasian and African-American offenders, with a mention of Hispanic offenders. The results of the research is equivocal. Some research has concluded that more African-American adolescents commit sexual offences than non-African American adolescents, while others have reached the opposite conclusion. The Safer Society report by Jackson (1984), states that 52% of the adolescent sex offenders were African-Americans, 28% were Caucasian, and 20% were Puerto Rican. Becker et al. (1987), also found that the majority of adolescent sex offenders were African-American (63%), followed by Hispanics (25%), and Caucasians (12%). A few other studies have also reported that the majority of the subjects are African-American (Becker, 1988; Oliver et al.,

1993; Van Ness, 1984). Numerous studies have reported that the majority of the offenders were Caucasian (Borduin, et al., 1990 (62.5%); Hains et al., 1986 (64%); Brannon & Troyer, 1991; Bremer, 1992 (70.5%); and Kahn & Chamber, 1991 (79%)). Davis and Leitenberg (1987), found mixed results when they reported that 64% of sexual offences were committed by white adolescents, and 35% were black., but that on forcible rape offences 42% of the offenders were white, while 58% were black. The equivocal findings may be due to the geographic location of treatment programme, among other factors. Becker (1988), admits that her sample of adolescent sex offenders who were previously victimized was "biased in that it over-represents Minority adolescents" (p. 196). Davis and Leitenberg (1987), report that "[n]o one has attempted to control for socioeconomic status, neighborhood living conditions, or offense densities" (p. 421), which may all affect the inclusion of various ethnicities in the studies.

TABLE 1: Studies Reporting Sex Offenders as Caucasian versus African-American.

	Caucasians as most frequent adolescent sex offender.	African-Americans as most frequent adolescent sex offender.
Total number of studies[1]	5	5

Education

The Safer Society (Jackson, 1987), reported that 66% of the adolescent sex offenders had completed grade 9 or less. Jackson (1987), also reported that poor school adjustment, high occurrence of long-term learning disabilities, and behavioural and attendance problems were common among the sex offenders, with 71% of the subjects receiving remedial education.

[1]Counts do not include Davis and Leitenberg's (1987) study.

Hains et al. (1986), reported that the adolescent sex offenders had a lower mean IQ (86) than the control group (97). Oliver et al. (1993), also reported an IQ level of 86 for the adolescent sex offenders. A Canadian study by Mathews (1987), reported that most of the adolescent sex offenders in treatment were average or above average intellectual functioning, followed by borderline functioning, and then developmentally disabled. Mazur and Michael (1992), found that all of their ten subjects had average or above IQ's. Surprisingly, Awad, Saunders, & Levene (1984), reported that adolescent sex offenders were more likely to be registered in a school, and less likely to be truant than a control group of delinquent adolescents. Kahn & Chambers (1991), also report that 75% of the adolescent sex offenders were enrolled in a school or vocational programme. They also reported, though, that "53% had histories of disruptive behavior at school, nearly 30% had truancy histories, and 39% were considered learning disabled" (p. 335). Overall school performance appears to be problematic.

The majority of the studies found that the adolescent sex offenders were at least average intelligence. This may be due to the fact that many programmes include in their admittance criteria the exclusion of developmentally disabled offenders because of the special attention they may need. By excluding this population there is a skew towards more intelligent subjects.

Family Structure

The studies that reported on the family background and structure all used wording related to "family instability" (Awad, Saunders, & Levene, 1984; Davis & Leitenberg, 1987; and Jackson, 1984). They all report broken, unstable, chaotic family lives, with periods of long separation from the parents, psychiatric disturbances in the family, sexual deviance, and

unsatisfactory parent-child relationships. Over half of the adolescent sex offenders in the study by Awad, Saunders, & Levene (1984), reported having either been abused by one of the parents or having witnessed abuse in their homes. There was also some report of substance abuse by the parents, and of the death of a relative or close friend.

Borduin et al. (1990), report that 31% of the sex offenders lived with both natural parents, and the remainder lived with their mothers, who were divorced. Becker et al. (1987), found 32% of offenders lived with their parents, 36% lived with only their mothers, around 2% lived with only their fathers, 16.5% lived in a group home, detention centre, or home for runaways, 12% lived with another family member, foster parents, or legal guardian, and about 2% lived on their own. Awad et al. (1984), also found that less than half of the offenders lived with both their biological or adoptive parents. Kahn and Chambers (1991), also support the finding that most offenders were not living with both parents (only 20%). Close to half lived with only their mothers, 15% lived with only their fathers, and 10% lived in foster care or with other relatives.

TABLE 2: Living Arrangements at Time of Offence.

	Both parents	Mother only	Father only	Group home[2]	Other families[3]	On their own
Borduin et al. (1990)	31%	69%	0	0	0	0
Becker et al. (1987)	32%	36%	2%	16.5%	12%	2%
Awad et al. (1984)[4]	40%	N/A	N/A	N/A	N/A	N/A
Kahn and Chambers[5] (1991)	20%	46%	15%	6%	7%	1%

[2]Group home includes group homes, detention centres or homes for runaways.
[3]Other families includes another family members, foster parents, or a legal guardian.
[4]This count includes both biological and foster parents, it did not include any other information on living arrangements.

Awad et al. (1984), reported that a majority of the adolescents (79%) had been separated from at least one parent, and that half of these separations took place during the boys' preschool years. More of the subjects were separated from fathers than from mothers (75% versus 55%).

There was also a report of serious family problems emerging either before the boy's birth or within the first three years (Awad et al., 1984). Over half (62%) either rejected or were emotionally detached from their mother, and 63% rejected their fathers, while 50% were emotionally detached from their fathers. Around 50% of mothers and fathers were lax in setting behavioural limits and controls.

The offenders tended to come from larger families with three or more siblings (Awad et al., 1984). These siblings also tended to be "delinquent, truant, emotionally disturbed, or had been placed outside the home" (Awad et al., 1984, p. 110). In contrast, Oliver et al. (1993), reported that the mean number of siblings for sex offenders was only 2.28.

Physical and Mental Health Histories

The physical health of the adolescent sex offenders was reported to be good, but that close to half had been identified as having suffered from emotional problems, close to 33% had received psychiatric treatment, and that 20% had been hospitalized for a psychiatric illness (Awad, Saunders, & Levene, 1984). Oliver et al. (1993), reported that only 14% of the sex offenders had a past history of mental health contact. Becker et al. (1987), reported that 97% of the adolescent sex offenders they studied had not been hospitalized for psychiatric illness.

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[5]This includes a 6% unknown for living arrangements.

Substance Abuse

There were few reports on substance abuse, most commented instead, on substance use. Hunter and Becker (1994), reported that 62% of the adolescent sex offenders consumed alcohol, but that none were intoxicated at the time of the offence. They also reported that only 39% used drugs, and that no offender had used drugs prior to the offence. Kahn and Chambers (1991), reported that substance abuse was only a problem for 37% of the youths. Van Ness (1984), also reported that alcohol and drug problems were present in 52% of the subjects. It was reported that over half used alcohol or drugs after an "anger raising" event. Davis and Leitenberg (1987), report that "claims of being drunk or stoned may be used more frequently, however, as a way to try to evade responsibility" (p. 420). Van Ness (1984), also emphasized this idea.

Pornography

In the one study which reported on pornography, 89% of the adolescent sex offender subjects reported using sexually explicit material. Magazines were the most common source of pornography (35%), followed by video tapes (26%), television programmes (15%), and books (13%). Of the offenders that used sexually explicit material, "74% reported that it increased their sexual arousal" (Hunter & Becker, 1994, p. 138).

Past Abuse

Truscott (1993), reported that 83% of the sexual offenders reported being physically abused, and that 44% reported being sexually abused. Kahn and Lafond (1988), reported that between 50-60% of their offenders disclosed histories of sexual abuse. Those adolescent sex offenders that had a history of physical or sexual abuse had higher arousal levels to both

deviant and nondeviant sexual cues than those sex offenders who had not been abused. Hunter and Becker (1993), also reported that those adolescent sex offenders who had a history of sexual abuse had more victims, and were equally as likely to have a male or female victim. Hunter and Santos (1990), reported that around 80% of the offenders who molested younger children were themselves molested as children. Awad et al. (1984), found that around 33% of the offenders had abusive or neglectful upbringings. Becker (1988), reported that only 19% of the adolescent sex offenders reported being abused. Of that 27 subjects that were abused, 3 were abused by strangers and 24 were abused by non-relatives whom they knew. Nine of the adolescents reported that they were verbally coerced, 8 were physically coerced, 3 experienced excessive physical coercion, and 7 were not coerced into engaging in the sexual behaviour. Kahn and Chamber (1991), found that 42% of their sample had been sexually abused prior to their offences. Most of the abuse occurred at the hands of an unrelated male. Forty-seven percent were reported to have been physically abused, with most often this abuse occurring at the hands of the biological father or the step-father.

TABLE 3: Percentage of Adolescents Sexually and Physically Abused

	Sexual Abuse	Physical Abuse
Truscott (1993)	44%	83%
Kahn and Lafond (1988)	50%	N/A
Hunter and Santos (1990)	80%	N/A
Becker (1988)	19%	N/A
Kahn and Chamber (1991)	42%	47%

Past Offences

The reports on past offences are divided into prior non-sexual offences, and prior sexual offences. The research is unequivocal in the reporting that offenders have committed prior

sexual and non-sexual offences. There is a discrepancy, though, in the percentage of offenders who did commit prior offences. The study by Becker, Cunningham-Rathner, & Kaplan (1987), report that 28% of adolescent sex offender subjects had been arrested for nonsexual crimes, and that 90% had been arrested at least once for a prior sexual offence. The Safer Society Report (Jackson, 1984), found quite the opposite percentages. About 66% had been arrested for prior nonsexual offences, and about 33% had prior arrests for sexual offences. Awad, Saunders, & Levene (1984), reported that 46% sex offender subjects had committed prior sexual offences, and that over 50% of them had been arrested for nonsexual offences prior to the current charge. Kahn and Chambers (1991), reported that about half of their subjects had a previous criminal record, only 5% had been convicted previously on a sex charge. Even though the results are equivocal, the general conclusion that can be reached from this past research is that a good proportion of the adolescent sex offenders had previous criminal records, and that at least some had previously committed sex offences.

Table 4: Percentage of Prior Sexual and Non-sexual Offences.

	Prior Sexual Offences	Prior Non-sexual Offences
Becker et al. (1987)	90%	28%
Jackson (1984)	33%	66%
Awad et al. (1984)	46%	>50%
Kahn and Chambers (1991)	5%	42%

Present offences

The categorization of the current offence was different for each research article, because of varying definitions and laws. Becker, Cunningham-Rathner, and Kaplan (1987), noted that of 67 adolescent sex offenders, there had been 60 completed molestations and rapes, 155 incidents of consensual incest, 4 cases of frottage, 50 incidents of voyeurism, and 2 cases of

exhibitionism. Awad, Saunders, and Levene (1984), reported that rape or attempted rape was the most common offence, followed by indecent assault, "toucherisms", exhibitionism, and sexual harassing calls or remarks. Borduin et al. (1990), also found that arrests for rape or attempted rape was the most common, followed by sexual assault, sodomy, and exhibitionism.

The Canadian data by Mathews (1987), reported that of 36 adolescent sex offenders there were 139 counts of sexual assault, 91 of child molestation, 25 of incest, 12 of buggery, 7 of exhibitionism, 2 of obscene phone calls, and 1 of bestiality. Brannon and Troyer (1991), found that there were 25 charges of fondling, 9 of heterosexual intercourse, 9 charges of fellatio, and 7 of sodomy. It was found by Davis and Leitenberg (1987), that 59% of the cases were for fondling, 23% for rape, 11% for exhibitionism, and 7% for other noncontact offences. Kahn and Chambers (1991), reported that most of the sex offences included fondling (57%) or intercourse (33%). Van Ness (1984), disclosed that 16 of the 29 subjects were charged with gross sexual imposition even if penetration had occurred, and that 13 were charged with rape.

Becker (1990), reported that fondling was the most common act, followed by anal penetration. The most common non-genital acts included voyeurism, frottage, exhibitionism, obscene call, mooning, and obscene letters. Jackson (1984), found that the most common charge was rape, followed by attempted rape, sodomy, and sexual abuse. Kahn and Lafond (1988), summarized that oral, anal or vaginal penetration are the most likely offence committed, and that "hands off" offences are rare. Bremer (1992), concluded that 71% of the subjects were child molesters, 27% were sexual aggressors, and 2% were non-touch offenders

(hands off). An overall summation of this area is very difficult due to the different labels used for possibly the same sexual act.

Victims' characteristics

Most of the victims are female, are known by the offender, and are younger than the adolescent sex offender. Hunter and Santos (1990), noted that of the subjects, 25% had only male victims, 40% had exclusively female victims, and 35% had both male and female victims. They also reported the mean age of the male victims was 6.73 years and the female mean age was 5.89 years. Kahn and Lafond (1988), also report that most offenders (40%) chose only female victims, followed by both male and female victims (33%), and then only male victims (20%). Approximately 95% of the adolescent sex offenders knew their victims. Awad et al. (1984), provided further support for the proposition that females are victimized more than males (84% versus 16%). Smith and Monastersky (1986), found that most victims are at least 4 years younger than the offender. Van Ness (1984), found that 32% of the victims were male, with most between the ages of 4 and 13 years. Van Ness (1984), found that teenage and young girls, between the ages of 6 and 18 years, was the largest category of victims, comprising 36% of the total victims. Surprisingly, the second largest group of victims (32%) in Van Ness'(1984) study, were adult women between the ages of 20 and 24 years. Smets and Cebula (1987), report that about 70% of the victims were females, between the ages of 3 and 9 years old. Around 50% of the offenders abused someone within their families.

Most of the offenders had only one victim (73%), 27% had two victims, and 8% had three or more victims (Kahn & Chambers, 1991). For one or two victims, females were the most common victims (76% and 67%, respectively). Only when the number of victims reached

three or more were there more male victims (54%) than female victims (46%). Kahn and Chambers (1991), also report that most of the victims were non-related children.

Most of the victims were female, were younger than the offender, and were known to the offender. As the number of victims increased the victim tended to more likely be male, and to be non-related.

Type of coercion

"Less physical force is used when the victim is younger than the offender than when the victim is the same age or older than the sex offender" (Davis & Leitenberg, 1987, p. 419). The most common types of coercion used were physical and verbal, followed by excessive physical coercion, and then noncoercion (Becker, Cunningham-Rathner, & Kaplan, 1987). Hunter and Santos (1990), found that the use of force or aggression (specific types were not mentioned) was used in about 60% of the cases. Kahn and Lafond (1988), also reported that over 50% of their subjects used some degree of physical force during commission of the offence, while others used threats, bribes, or special games to commit the abusive acts. Kahn and Chambers (1991), reported that 33% of the offenders used verbal coercion, and 42% employed "either threat or use of violence and/or weapons" (p. 336). Van Ness (1984), reported that 36% of the female victims, and 25% of male victims were coerced with knives or guns. Awad et al. (1984), found that only two of the 32 victims were threatened with weapons.

There is no such thing as "noncoercion" or "nonuse of power" when a sexual assault is being committed, since all offenders must have some type of power over their victims in order to be able to commit the offence. The power could be as simple as the offender being in a

position of authority. A small child learns that a person larger than him/herself has more power, so that, physical size, even if not used directly in committing the crime, is another possible source of power over the victim. Since, the victim will always wonder whether the offender will use his strength and size in the future, the offender already begins with this advantage.

Chapter 3 Sex Theories

There have been numerous theories offered to explain the occurrence of deviant sexual behaviours of adolescents. The theories come from medical, psychological and sociological frameworks.

One place to begin, is to examine normal sexual development. Barbaree, Marshall, and Hudson (1993), explain that healthy sexuality includes six components. The youth will learn about intimacy and relationships through interactions with his peers, and develop an understanding of his roles. The youth must adapt his body schema to the physical changes that he is experiencing, and he must integrate erotic feelings and experiences into his life. Societal standards and practices concerning sexual expression will influence what is learned and how experiences and emotions are handled. Finally, there must be an understanding of the reproductive processes. "Sexual development involves integration of one's sense of sexuality into one's personal relations, this integration is influenced by the demands or standards of the cultural context" (Barbaree, Marshall, & Hudson, 1993, p. 87). If the youth has not integrated the culture standards and his own sexuality, then the youth will not view his behaviour as being deviant, even if society does. The treatment for this youth is to teach him society's standards, and how to integrate his own sexuality into the culture's standards.

The psychological theories include psychoanalytic and social learning approaches. Social-learning theory is sometimes also labeled the cognitive-behavioural approach, or the socio-behaviourist approach. The main focus of this perspective is to reduce abnormal sexual arousal. It is assumed that "all behavior is learned" (Sapp and Vaughn, 1990, p. 134), therefore, abnormal behaviour is a learned behaviour. Based on this assumption, the

cognitive-behavioural approach asserts that "abnormal behavior is extinguished and replaced with responses which are socially acceptable" (Ibid.). The primary hypothesis behind this theoretical perspective is the pairing of previously neutral stimuli with stimuli that are sexually arousing. This is comparable to the classical conditioning approach. Since the abusive behaviour is assumed to be learned, it is considered to be cyclical in nature, making it similar to the general discussion of family violence. The relationship between the stimuli is strengthened over time by repeated deviant thoughts and fantasies with masturbation or other sexual activities. Attention is also paid to the meaning that the youth assigned to any previous abuse. Previous abuse becomes especially important if the abuser was seen as an attractive or powerful model.

If the adolescent is exposed to physical aggression and marital violence within the home, then this is learned as acceptable behaviour. Modeling may also occur if there is exposure to pornography or to an aggressive model. The type of sex offence is hypothesized to be the same as the acts the offender was previously exposed to, either through direct abuse, or through indirect exposure. The duration of the abuse or exposure to pornography or an aggressive model "is important insofar as learning becomes more ingrained with frequency of exposure" (Orr, 1991, p. 95). If the youth has low self-esteem, he may perceive the media messages which objectify and demean women and children, and that project sexual scripts that do not require social skills or intimacy, as the best methods to satisfy his sexual interests. These sexual scripts are used in fantasies, that lead to the conditioning of these scripts as a normal and appropriate way to behave.

The social learning theory assumes that sex offenders "frequently possess a preference for deviant sexual activities, . . . and that such interest may result in persistent patterns of behavior" (Barbaree, 1990; as in Hunter & Becker, 1994, p. 133). This perspective has also assumed that "sexual interest and arousal patterns are measurable and potentially responsive to treatment" (Ibid.). It is not agreed whether self-report measures, which are the most common measure of sexual interest and arousal, are distorted and inconsistent, and, therefore, whether a more objective measure should be used. As mentioned above, it is also assumed that the deviant behaviour is learned, with no innate components.

The psychodynamic approach offers another explanation for the behaviour of adolescent sex offenders. This perspective is an "outgrowth of the medical model" and "operates under the premise that the offender is ill and needs medically based therapy" (Sapp & Vaughn, 1990, p. 134). The destructive sexual offences might be "symptomatic of pathological early experiences, unmet needs, and unresolved internal conflicts" (Orr, 1991, p. 90). For sex offenders with a history of acute or chronic trauma, this unresolved trauma prevents the adolescent from learning healthy attachment to adults, and also from "developing an internalized sense of personal accountability" (Bremer, 1992, p. 328). A loss of trust in nurturing or parental relations may be present. This loss will have occurred during infancy or childhood. For the abused adolescent sex offender, abuse by a male, especially a father-figure, could lead the youth to identify with the abuser and thereby continue the sex offences. It has been argued from this perspective that these sex offences may occur because the ego is continuously striving for perfection, which can lead the youth to actually take pride in his sex offences. If the abuse of the youth was over an extended period of time, the youth may be

overcome with feelings of helplessness, and powerlessness. These feelings can lead to the belief that he has no control over what occurs, and therefore, is unable to stop his acts. Anger and resentment combined with guilt and fear are common emotions experienced by the adolescent (Orr, 1991). These emotions result in confusion, conflict and instability.

It has also been suggested that the abusive acts are a re-enactment of the abuse experienced by the youth himself, and that the acts serve as an attempt to resolve the trauma from the previous abuse. It may also involve an attempt to gain personal power and control that were absent when the adolescent was a victim. The abusive behaviour is, according to Orr (1991), "a meaningful though not necessarily conscious attempt to assert autonomy, achieve individuation from the family of origin, regulate internal tensions, cope with conflicts and integrate one's experiences into a stable and coherent personal identity" (p. 89).

Hormonal abnormality theories have focused on the hormonal imbalance of testosterone in the sex offender. Although the findings are not conclusive, the results in general suggested that serum testosterone is higher in some sex offenders (Ben-Aron, Hucker, and Webster, 1985). The organic treatment attempts to alter the chemical balance of the offender. The biological perspective employs Cyproterone Acetate (CPA), Depo-Provera, and medical castration.

Brain pathology among sex offenders has also been a recent focus of study in the area of neuropsychology. The research has focused on the temporal lobe of the brain, which is linked to the limbic system. The limbic system may play a large role in sexual behaviour. In the temporal lobe, structural damage, abnormal brain waves, tumors, and seizures have been

found. Suggestions have been made that there is neurological 'miswiring' in the brains of sexual offenders.

Baron and Straus (1989) detail four macrosociological theories that have contributed to the occurrence of rape. Evidence was found that "the lower the status of women relative to men, the higher the rape rate is" (Baron and Straus, 1989, p. 185). This reflects the theory that "in a male-dominated society, rape both reflects the low valuation of women and contributes to their subordinate position in the gender stratification system" (Ibid.).

It was found that a lower level of social control and integration contributes to a higher level of rape. On the other hand, since social disorganization erodes traditional patterns, including patterns of domination and subordination, "a reduction in gender inequality, in turn, contributes to a reduction in the rape rate" (Baron and Straus, 1989, p. 187). In societies that are relatively violent, it was found that women are devalued, and therefore, more often assigned subservient roles. A violent society is associated with a higher incidence of rape. These theories were included to try to offer as many theories as possible. The sociological theories will not be elaborated upon in this paper. These theories may account for where the social learning takes place. It is society which allows certain actions to go unpunished, and produces the media, so these then in turn relate to the social learning theory presented above.

Graves, Openshaw, and Adams (1992), state that most of the theoretical frameworks used to explain adolescent sex offenders are from the psychoanalytic framework. Yet, as will be seen below, the typical treatment programmes include cognitive-behavioural treatment methods. Even in an article by Orr (1991), which discusses the psychoanalytic model, the final section mentions treatment including a combination of psychoanalytic and cognitive-

behavioural treatments. Most of the more recent articles (Hunter & Santos, 1990; Annis, 1982; Sapp & Vaughn, 1990; Becker & Kaplan, 1988; and Bremer, 1992) appear to be employing the cognitive-behavioural approach more often. Barbaree, Marshall, and Hudson (1993) also bring attention to the "need to develop specific theories for each type of offence that emphasize different processes" (p. 137).

Chapter 4 - Treatment Programmes

In this chapter the treatment programmes which have grown out of the previously mentioned theories will be presented. The treatment programmes are divided into different categories, following the categorization used in The Management and Treatment of Sex Offenders (1990). The first category will be cognitive-behavioural programmes, which is divided into approximately eight areas. The next section will concentrate on relapse prevention programmes. This will be followed by self-help programmes and then a final area which will be a "catch-all" for programmes that have not neatly fit into the above schema. The last section of this paper will outline those programmes that have conducted research and have provided outcome data.

Group therapy is utilized as the primary modality for treatment and intervention. The programmes differ in the lengths of treatment, but the range is anywhere from 6 to 33 months. Most facilities shorten their programmes, even if they believe that the offenders need longer treatment, because the usual length of the sentence an adolescent receives is less than two years. The quantity of treatment varies from 2 to 3 hours per week to as much as 25 hours per week (Borzecki & Wormith, 1987).

Cognitive-Behavioural Programmes

Cognitive-behavioural programmes concentrate on changing the behaviours and accompanying thoughts of the youth. These types of programmes "are based on well established research findings that deviant arousal patterns, once established, are frequently maintained by pairing thoughts and fantasies of the deviant activity with masturbation" (Kahn

& Lafond, 1988, p. 146). The programmes are also influenced by social learning and modeling. These programmes include: social skills and assertiveness training, victim empathy, covert sensitization, cognitive restructuring (thinking errors approach), satiation therapy, sex education, accountability therapy, and aversive arousal.

Social Skills and Assertiveness Training.

Social skills and assertiveness training is based on the idea that past behaviours are learned and "have been patterned after significant others and may foster a repetition of problematic interactions" (Lombardo & DiGiorgio-Miller, 1988, p. 51). Since these maladaptive behaviours are believed to be learned, it is also believed that these behaviours can be replaced with more adaptive ones. The offenders' families usually have been socially isolated, experienced frequent mobility and changes in the collective household. These problems can result in immaturity due to the neglect of dependency needs during childhood (Kahn & Lafond, 1988). Social skills and assertiveness training is one of the most common treatments used in sex offender treatment. Becker and Kaplan (1988), report that one measurement of social skill deficits is the MESSY, and through self-reports, and through parental reports.

Sapp and Vaughn (1990), reviewed 30 treatment programmes in 17 states and found that 26 programmes (87%) currently implemented social skills acquisition training and that 29 (97%) would implement it if they had the resources. Fifteen out of the 22 articles reviewed for this paper mentioned the use of social skills treatment.

Annis (1982), states that adolescent sex offenders have "difficulties in interpersonal relations" (p. 224), which is the result of inadequate social skills, and a lack of assertive

responses. Social skills training involves peer relations with age-appropriate peer groups including dating skills; learning how to express anger and love, and how to manage stress; personal hygiene; job interviewing, and active listening. Since most adolescent sex offenders "use and condone physical aggression as the preferred form of conflict resolution, adolescents are taught alternative means of problem solving" (Becker, 1990, p. 364). Graves, Openshaw and Adams (1992), describe the Adolescent Social Skills Effectiveness Training Program (ASSET) that has been developed. It included four elements: modeling, rehearsal, encouragement, and homework assignments. "Participants observe the behaviour, verbal and nonverbal, of an expert demonstrating situationally specific social skills" (p. 143), followed by a discussion of the skill and its application. After the discussion, there is rehearsal involving role playing of the skill that includes approximation towards the skill. Role modeling is also performed by male and female cotherapists during treatment. Encouragement is given for the effort extended, and constructive criticism is given regarding performance. The homework assignments allow for continuous use of the skills. The ASSET programme teaches eight social skills: giving positive feedback, giving negative feedback, accepting negative feedback, resisting peer pressure, problem solving, negotiation, following instructions, and conversation.

Groth, Hobson, Lucey, and St. Pierre (1981) incorporate assertiveness training into the treatment programme. Assertiveness training is to "diminish passivity or to modulate oppressiveness" (p. 267) in order to change the behaviour. The passivity of the adolescent offender is caused by lack of self-esteem and the fear of rejection (Davis and Leitenberg, 1987). This passivity may lead to social isolation from the peer group.

Sex Education.

Sex education was the second most common type of treatment mentioned in the articles reviewed. Becker and Kaplan (1988), report that The Math Tech Sex Test is utilized to measure the deficits in sexual knowledge and values. Thirteen of the 22 articles mentioned sex education as part of the treatment. Sapp and Vaughn (1990), mentioned that 29 out of the 30 programs reviewed implemented sex education. Sex education can include consentual and appropriate sex, sexual communication, sexual myths, pubertal development, birth control, pregnancy, homosexuality, homophobia, sexual positions, birth, and sexually transmitted diseases (now including HIV transmission). The teaching of sexual knowledge also includes anatomy and physiology, along with sexual intercourse, and conception. Coleman (1988), states that a sex education programme includes value clarification as well the practical knowledge of sex. Numerous other programmes also reported including value training (Becker, 1990; Hunter & Becker, 1994; Kahn & Lafond, 1988). "Typically such offenders have received no dependable sex education" (Groth et al., 1981, p. 267), and what knowledge they have tends to be distorted, helping to maintain the problem behaviour. The youth offenders have inadequate feelings of sexuality, and many false ideas. One method for teaching sexual knowledge includes filmstrips followed by discussion (Hains, Herrman, Baker, & Graber, 1986). Some programmes also include a focus on psychological attitudes, more specifically; deviant sexual attitudes towards sexually related issues. These include sexual stereotypes that devalue females, and hold "men as all-knowing, controlled, powerful, and fearless" (Kahn & Lafond, 1988, p. 143).

Cognitive Restructuring.

The thought processes are a major force in allowing the youth sex offender to commit these sex offences. The adolescent has "many destructive beliefs and myths pertaining to rape and sexual abuse of children" (Davis & Leitenberg, 1987, p. 424). The cognitive distortions allow for denial of having committed the offence, of the impact that the crime had on the victim, including that the victim deserved it, and about what constitutes normal behaviour. Cognitive restructuring programmes intersect with sex education because many of the distortions and rationalizations are based on sexual attitudes and knowledge. It also overlaps with accountability therapy, as both focus on the denial of the crime. This treatment is also known as the "thinking error" approach. Of the articles reviewed for this paper, 10 mentioned using cognitive restructuring or thinking error approach. Sapp and Vaughn (1990), mentioned that only 7 (23%) of the 30 treatment facilities used this method.

The process of identifying and confronting the cognitive distortions is a very difficult process since the offender invests a lot of time and energy in these rationalizations and denials. Becker and Kaplan (1988), report utilizing The Cognition Scale to measure inappropriate beliefs. As long as the distortion is believed by the young offender, he can continue to commit offences and is not required to face his behaviour. Coleman (1988), describes one programme where the offenders compile a list of distortions that they use, and then the distortions are role played in a group setting with the other offenders challenging each other's beliefs.

Berenson (1988), also depicts the adolescent sex offender as having the idea of being "super unique, literally one of a kind" (p. 71), and that no matter how low the self-esteem the

offender will believe himself to be superior to other people. From these beliefs comes what Berenson calls "magical thinking", where the offender can do whatever he wants and where the whole world revolves around him. These beliefs also perpetuate "super optimism" because the young offender believes that he can never get caught for the offence and that "he is above and beyond the law" (p. 72). These beliefs come from power lust, which leads to a literal cutting off the cognitive process of any awareness of being apprehended. If he does consider the possibility of being caught, he then believes that he can beat the system. The excitement comes from doing the forbidden.

Victim Empathy.

Victim empathy is used to increase the adolescent's understanding of the impact of the crime on the victim (Davis & Leitenberg, 1987). The general purpose of this method is to help the youth focus on the other rather than the self, and to help them focus more accurately on another person's internal frame of reference (Rowe, 1988). According to Jonathan Ross (1988), victim empathy is the most important aspect of the treatment because it helps to break the myths that perpetuated the crimes. One of the overall goals of this therapy is to promote warmth, trust, and openness by helping to develop empathy for the victims and for other people. Sapp and Vaughn (1990), state that 28 (93%) of the 30 programmes examined, used victim empathy and that 100% would use this method if they had the resources. Discussion of both the short and long term effects of the crime on the victim takes place. Every detail is used - physical, emotional, social, and behavioural effects. It is described where and what the victim must do after the offence, and what the victim is experiencing in each of these four areas.

Victims are discussed as individuals, and the victim is examined as a fellow human. One of the methods used in victim empathy is to have guest speakers, such as, Detectives from a Sex Crimes Unit, a victim of a sexual assault, or a counselor from one of the crisis programs to attend and discuss the aftermath of the crime. Media and videos are often used to start discussions around specific topics. The reading of victim statements is "often discomforting for the group members to hear the details and consequences related to offenses, this process fosters an acknowledgment of another person's pain" (Lombardo & DiGiorgio-Miller, 1988, p. 51). In a few victimology groups, there are supervised meetings between offenders and victims.

Another method of teaching victim empathy is for the offender to "get in touch with whatever victimization he has experience in the past" (Ryan, Lane, Davis, & Isaac, 1987). By feeling the pain and other emotions as a victim, the offender will then be more capable of relating to his own victim.

Accountability Therapy.

Accountability therapy is commonly associated with the adolescent offender taking responsibility for committing the crime. Sapp and Vaughn (1990), report that 26 of the 30 programmes reviewed employed accountability therapy, and that all of the 30 programmes wanted to use this treatment. Davis and Leitenberg (1987), use peer-group confrontation techniques to increase acceptance of responsibility, and accountability for the sex crime. Many programmes require the adolescent to admit to some aspect of the crime and being responsible for his behaviour as a prerequisite to starting the treatment programme.

Most young sex offenders move "through a process of denial to minimization and justification prior to understanding the choice he made to commit a sexual offense" (Bremer, 1992, p. 328). The denial can be very difficult to stop because for the offender, admitting to the crime could have very negative consequences for him. Denial protects the offender from the stigma and shame attached to being sexually deviant. The denial also protects the offender from alienation and rejection by family and friends. Protection against further legal sanctions is also a possible consideration of the offender. Kahn and Lafond (1988), have found that offenders are unable to fully acknowledge responsibility for the crime they committed until they have dealt with their own self-blame and guilt from their own victimization. Bremer (1992), warns that "resolution of trauma is not sufficient to change a preferential behavior pattern" (p. 328). The acceptance for his behaviour also includes an understanding of the factors that precipitated the offence. By taking responsibility for the offence, he begins the process of being able to share, trust, and self-disclose (Smets & Cebula, 1987). This area overlaps with relapse prevention.

Covert Sensitization.

Covert sensitization is one method used to disrupt the cycle of coming in contact with the victim. Its purpose is to teach the offender how to control his sexual offending behaviour. The offender must be slowed down to allow him to become aware of the chain that leads to the offending behaviour. Becker and Kaplan (1988), utilize the Sexual Interest Card Sort to determine the deviant sex interests of the youth. Judith Becker describes one method in this area of treatment as the offenders "first imagine and then verbalize on audiotape the various feelings or experiences that lead them toward committing a deviant sexual act, and then

immediately bringing to mind highly aversive images" (1990, p. 364). On the tape, the youth should record how he is feeling, what his sexual fantasies are, and what he wants to do to the victim. He should describe how he found the victim, what he said, and how he got the victim to comply. The youth then stops and switches to the aversive scene before the actual crime is committed. Coleman (1988), uses a neutral scene to begin with to get the adolescent started, before the aversive scene is used.

Hunter and Santos (1990), examined a residential programme which began with a neutral scene, followed by a sexually deviant scene, and then the aversive consequence, and ended with an escape scene. The escape scene was a pleasant scene which showed the rewards for good impulse control or for sexual activity with a consenting peer. In one group, the youths are required over a three week period to complete eight 15 minute tapes. Internalizing the aversive image is what needs to occur, then it will be more likely to be used when required. By practicing the aversive image, the internalizing process will occur. A little less than a quarter of the programmes reviewed by Sapp and Vaughn (1990) used covert sensitization.

Satiation Therapy.

The most common method of satiation therapy is the use of masturbation and verbalization on tapes. Satiation therapy is based on an extinction model. Coleman (1988), describes the process as having the offender masturbate to a non-deviant sexual fantasy until he has an orgasm which reinforces the "right kind" of arousal. The offender then continues masturbating to a deviant fantasy in the refractory period following the orgasm so that it becomes uncomfortable and boring. The purpose of satiation therapy is to decrease the amount of arousal to deviant fantasies. Another method involves verbalizing

(nonmasturbatory) the fantasies repetitively until the point of becoming bored with the deviant fantasy. Coleman uses slides in a laboratory and has the youth verbalize a deviant fantasy connected to the picture until they no longer show any arousal to the fantasy. The satiation session can last about sixty minutes, with the first section consisting of consensual sexual activity, and the second section consisting of repetition of the deviant sexual fantasy. In an inpatient programme examined by Hunter and Santos (1990), satiation therapy was conducted about once a week for each patient.

Sapp and Vaughn (1990), report that only one out of 30 programmes used satiation therapy and that only 11 would use it if there were resources available. This is a very difficult method to use because of the possibility of faking the satiation procedures. Therefore, it is usually reserved for adolescent offenders who are very motivated.

Aversive Arousal.

A last cognitive-behavioural component includes aversive arousal with the use of shock or obnoxious odours. Clients get to choose their own shock frequency and usually receive a sample shock to ensure their consent. Ryan et al. (1987), report the use of ammonia caps to change deviant sexual arousal. It is not a very popular method of treatment as Sapp and Vaughn (1990), report that only 2 programmes currently employ this treatment and only 13 out of the 30 would use it if they had the proper resources. Borzecki and Wormith (1987), report that in Canada, 75% employed an aversive component in their treatment programmes compared to very few of the U.S. programmes surveyed. Margolin (1984), mentioned that shame aversion is one method used in some programmes. Shame aversion involves the offender telling about his deviant behaviour before a group of observers. The purpose is to

make the offender feel the shamefulness of his acts. Margolin (1984), mentioned that other programmes use this, but the writer did not find any mention of it in other programme descriptions.

Relapse Prevention

Relapse prevention is based on the belief that there are precipitating events which can cause the offender to relapse and commit another crime, and that sexual offences do not occur due to impulsiveness, nor because of severe psychiatric disorders (Barbaree, Marshal, & Hudson, 1993). It is also commonly known as the sexual assault cycle. This component of therapy is usually the last section in the treatment programme. Relapse prevention is regarded by some not as a treatment component, but as a maintenance component. The adolescents are evaluated after this component and then released or referred for further treatment. This treatment method is meant to teach the steps that should be taken to avoid relapses. Attention is given to what events and emotions lead to the offending behaviour, what the motives are, and the progression of the offender's behaviour. Focusing on emotions, self-esteem and circumstances before, during, and after the offence can help the offender gain control over the inappropriate sexual arousal. The offender "must understand the cognitive, behavioral, situational, and psychological events which contributed to his offense" (Ryan et al., 1987). The Seemingly Unimportant Decisions (SUD's) are stressed as being the important precursors to the offence. These SUD's build across time, that include fantasies, thoughts, and behaviours that can either be deviant or nondeviant. Within the setting of group and individual therapy, an individualized prevention plan is developed, which includes the

individual's own feelings, behaviours, and thoughts. Interventions for the feelings, behaviours, and situations should be practiced in the treatment setting.

Sapp and Vaughn (1990), did not find that relapse prevention was a very popular treatment method. Only 5 of the 30 programmes reviewed used this method, and only 10 of the 30 indicated that they would use it if they had the resources. Of the 22 articles reviewed for this paper, 9 discussed using relapse prevention in their respective treatment programmes. Parents should also be taught about relapse prevention as they are the ones that should keep a watch on their child's behaviour. In one programme examined by Mazur and Michael (1992), it was reported that each adolescent must present his personalized prevention plan to his parents. Methods are discussed as to what should be done when the adolescent appears to be slipping back into old routines and dysfunctional coping styles (Steen & Monnette, 1989). In order for this treatment to be successful the young offender must "believe that he has the power to stop himself along the way before abusing again" (Lombardo & DiGiorgio-Miller, 1989, p. 47).

Self-help Programmes

Guided self-help programmes are to increase the insight and awareness the offenders have into the cause of their offence (Solicitor General, 1990). This is also known as insight-oriented therapy. Insight-oriented therapy focuses on "intrapsychic feelings, needs, and conflicts that may have contributed to the problem" (Hunter & Santos, 1990, p. 242). Self-help therapy overlaps with relapse prevention, and other types of programmes, since the offender must look carefully at his own behaviour. This is a very important concept, since young offenders can be taught all different types of methods to stop offending, but unless

they truly have insight into themselves and believe that this behaviour is destructive, but controllable, none of the programmes developed will work. Self-help in this sense will focus on more general types of topics not just sex offending. A self-inventory is one example where the youth is to list all of his positive and negative characteristics. These can include intelligence, unpopularity, looks, et cetera. An autobiography also teaches the youth to be self-observant. "Through self-knowledge comes increased feelings of self-acceptance and self-control" (Groth et al., 1981, p. 269). Through self-insight the youth may examine issues of self-esteem, powerlessness, et cetera. The self-help begins by obtaining a detailed life history. This also helps to resolve the adolescent's own victimization, through differentiating between initiator, and recipient.

The general theme in self-help treatment is low self-esteem, and what Ross (1988) calls "offence syndrome". Offence syndrome is where the offender sees himself as the victim, which in turn justifies his criminal behaviour. The purpose of the self-help method is to help the offender gain insight into his whole world and all of his behaviours, as he has other dysfunctional behaviours than the sex offending behaviour.

The methods described above, appear to contribute the majority of treatment techniques being employed by therapists to treat sex offenders.

Others

Narrative Therapy.

Narrative therapy is a more recent therapeutic development which has grown out of the Australian context. This therapy is currently being used in the treatment programmes for adolescent sex offenders in 2 of the treatment programmes being researched in the present

study. It has not been found to have been documented in the literature on the treatment of adolescent sex offenders. The incorporation of narrative therapy into 2 of the treatment programmes is one of the differences between those programmes and the 2 other treatment programmes.

Narrative therapy has embraced Foucault's analysis of power and knowledge. Certain covert knowledge techniques (such as, making the problem one of the person's own characteristics) may "inadvertently disempower persons and may empower problems in the process" (Karl, 1990, p. viii). Certain characteristics are attached to the client by other people with which the client interacts. By acting on this knowledge of the characteristics, the people increase their power over the client. The problem becomes oppressive to the person because the problem determines which aspects of the lived experiences are selected for storying, and what meaning is attached. By externalizing the problem, it then becomes separated from the person, since the externalizing process objectifies and personifies the problem (White and Epston, 1990). Distinguishing the problem from the person diminishes the power other people have over that client, since the problem is no longer connected to the person.

To externalize the problem the person begins by "storying" his or her life. Specific events in the person's life must be combined in a linear fashion. Experiences must be storied "in order to make sense of our lives and to express ourselves, . . ., and it is this storying that determines the meaning ascribed to experience" (White and Epston, 1990, p. 9). Not all experiences are storied, since life experiences are much richer than any discourse can yield. It is from these unstoried portions of our experiences that alternate stories can be found. These alternate stories are known as "unique outcomes". The unique outcomes are identified

through the externalization of the problem. Externalizing the problem allows for mapping of the influence the problem has had over the person and over his or her relationships. By mapping the influence of the problem, an exploration is allowed of times when the problem could have gained influence over the person, but did not. These times are examined, become the unique outcomes, and then the problem is restoried using these unique outcomes. The person performs the alternate story.

Family Therapy.

Family therapy is used in some programmes to help the family accept that the youth committed a sex offence, and to help change the dysfunctional skills that may have assisted the adolescent towards this offending behaviour. Family therapy can take the form of parent group treatment, and usually includes only the parents, or individual family therapy, that includes all family members. Some programmes include both methods. Parent group treatment usually involves general discussions about the same topics that the youth are going through, and can also include effective parenting strategies.

Steen and Monnette (1989), describe a programme that consists of sexuality and sexual education, problem-solving, assertiveness, relapse prevention, communication, victim empathy, family responses, and feelings. Individual family therapy focuses more specifically on the particular problems of each family, and includes all family members. Individual family therapy can include the same areas as the group therapy, as well as, power relations, family alliances, roles, boundaries, affection, decision-making, rules, handling of new ideas or situations, and religious and cultural mores (Ibid.). Sapp and Vaughn (1990), report that out of 30 programmes, 11 used family therapy. If possessing the resources, the majority of these

programmes (83%) would employ this treatment. A multisystemic treatment programme described by Borduin, Henggeler, Blaske, and Stein (1990), included a family relations section that examined family cohesion and parental supervision. Some programmes view family involvement in therapy as more essential to the treatment of the adolescent sex offender than other programmes.

Medical Programmes.

Medical or biological treatments come from the pharmacological field. The main focus of these treatments is on hormonal balance. These can include surgical castration, Cyproterone Acetate (CPA) or Androcur, Medroxyprogesterone Acetate (MPA) or Depo-Provera, and stereotaxtic neurosurgery. Sapp and Vaughn (1990), revealed that only one out of thirty programs was using an organic treatment - Depo-Provera. It was not a widely mentioned form of treatment in the articles reviewed here.

Vocational Training, School Performance, and Recreation.

Annis (1982), mentions that in one programme the vocational training involves small engine repair, electrical wiring, food service, office education, and a patient newspaper. Most programmes also indicate that regular school participation is important. Some programmes also include reports on school attendance, and on the progress and accomplishments being made at school. This may include an examination of the offender's intellectual and cognitive abilities. Participation in recreational activities is also deemed as important as they can help to increase the self-esteem. There is praise for effort as well as success. Recreational activities can help to teach cooperation, along with, assertiveness.

Substance Abuse Therapy.

A few programmes require the youth offender to have already received treatment for alcohol and drug abuse before beginning therapy for sex offending. The programme described by Annis (1982) includes substance abuse treatment as part of the whole treatment process. The access to alcohol and drugs is controlled by security, and inspections of the living units from time to time help to discourage contraband from being used. The nonproductive nature of substance abuse is discussed and through peer group support, abstinence is encouraged. Insight into the reasons for substance abuse is provided in individual psychotherapy, with alternative responses to problems being taught.

Psychological Therapies.

The last group of programmes includes other psychological therapies than cognitive - behavioural treatments. Individual therapy is usually the focus of these treatment methods. Psychotherapy is used because it is believed that deviant sex offending behaviour is the result of "pervasive, intrapsychic and interpersonal problems" (Annis, 1982, p. 224). This comes from the medical model assumption, that the offender is ill and needs medically based therapy.

There are many different frameworks that psychological therapies take other than those mentioned. Borduin et al. (1990), described possible theoretical orientations as psychodynamic, and humanistic, as well as phenomenological. Other orientations include guided interaction therapy, gestalt therapy, Rational Emotive therapy, Transactional Analysis (Jackson, 1984), hypnotherapy, and reality therapy (Cotton, 1987).

Individual therapy may also involve dealing with the past victimization of the adolescent offender, which may include unresolved trauma from childhood.

Labeling.

Margolin (1984), states that labeling the adolescent as High Risk Offender (HRO) helps to deprive the youth the ability for him to deny or minimize his offence. It also helps the treatment staff in not being deceived by the smoke screen of the "good boy" who is really cooperative and likable. Margolin (1984), remarks that the HRO label helps to keep the offence in the open, and to minimize manipulative attempts of the youth to escape responsibility.

Recidivism Research of Treatment Programmes

Since most articles discussed multiple programmes operating within one treatment facility, each study will mention the types of programmes employed and then the recidivism rate found. Recidivism will be taken as the number of adolescents who have been reconvicted of new charges. Where follow-up time periods and definitions of "new charges" or "new convictions" are articulated in the studies, this information will be provided.

In a study conducted by Dr. Donald Cotton (1987), individual therapy, relapse prevention, and social skills acquisition were used. It was found that of the 122 adolescent sex offenders accepted for study in the three juvenile sex offender treatment programmes, only three committed new offences upon release. The three offences were for non-sexual offences -- PCP use, drug sales, and assault. No offender was charged with a new sex offence.

In a study by Kahn and Lafond (1988), at the Echo Glen Children's Centre, social skills training, cognitive restructuring, sex education, accountability therapy, aversive arousal, and

individual therapy were used. Three hundred and fifty adolescents were followed between 1981 and 1986. Nine percent of the offenders committed new sex offences, while 8% committed new non-sexual offences. In another study by Bremer (1992), individual therapy, self-help, relapse prevention, accountability therapy, and victim empathy training were used in the treatment programme. Bremer (1992), found that 6% of the subjects were reconvicted of new sex offences, compared to the self-report rate which reported a 11% recidivism rate. The highest rate of recidivism was found for adolescents who had been in the programme for less than six months. The percentage of recidivism per time slot decreased steadily with no repeat offenders being reported for those who had spent more than 15 months in the programme. All of the repeat sex offence cases were released for less than 5 1/2 years from the programme.

Becker (1990), employed satiation therapy, cognitive restructuring, covert sensitization, social skills training, and sex education. It was found that only 5 adolescents out of 52 (9.6%) who were followed out of the treatment programme had committed new sex offences. There was no report about other non-sexual offences. Another study by Becker (1990), found that 6 young offenders out of the 86 who had gone through the training had re-offended (7%).

In a study by Borduin et al. (1990), a comparison was made between adolescents who took part in multisystemic therapy and those who were involved with individual therapy. Multisystemic therapy (MST) included numerous cognitive-behavioural treatments, such as, accountability therapy, cognitive restructuring, victim empathy, and social skills training, and others, such as, school performance, and family therapy. The individual therapy (IT) included psychodynamics, humanistic, and behavioural approaches. The recidivism rate for the MST group was 12.5% for sex offences and 25% for non-sexual offences. The IT group, in

contrast, had a 75% recidivism rate for sex offences and 50% for non-sexual offences. There was a statistical significant difference between the rate for sex offences, but not for non-sex offences.

In a 1991 study by Brannon and Troyer, a comparison was made of the recidivism rates between sex offenders and non-sexual offenders. The treatment programmes used were self-help methods, relapse prevention, and accountability therapy. It was found that 34% of the sex offenders were reconvicted for new felony convictions. Only one of the new charges was a new sex offence, most charges were for property crimes. Of the non-sexual offenders, 15.8% were reconvicted for new felony charges. Again, most were for property crimes, with no new sex offence charges.

In a preliminary survey by I. Jackson (1984), there were three programmes briefly examined with the presentation of recidivism rates. There was no mention of what types of treatment each programme used, but the general treatments mentioned included family therapy, sex education, victim empathy, accountability therapy, individual therapy, relapse prevention, substance abuse treatment, and social skills training. The first programme in Denver, Colorado was developed for very serious offenders. The programme has released 11 sex offenders with only one reoffending. There is no mention whether this is a sexual or nonsexual offence. The second programme is located in Minnesota, and is an open residential programme. There have been 22 offenders released, with only one committing a new sex offence. The third programme is a community based programme, also located in Minnesota. Twenty-eight offenders completed the six month treatment programme, with no reports of recidivism.

Finally, in one discussion of medical treatments of sex offenders, Bradford (1990), summarized recidivism research that has been conducted on surgical castration. When long periods of time (up to 20 years) were used for the studies, the recidivism rate decreased from 80% to less than 5%.

Other Data Outcomes

In a study by Hains, Herrman, Baker, and Graber (1986), the programme evaluated used social skill acquisition, and sex education. The outcome measure used to evaluate the treatment programme was the change in attitudes and knowledge pre- and post-treatment for adolescent subjects versus a control group (waiting group). It was found that on the Sexual Knowledge Test, there was a significant improvement for the experimental group over the control group. There were also significant improvements on the Adolescent Problems Inventory, but no change for the control group. The "analyses of moral judgment data revealed no significant changes in either group on the Defining Issues Test" (p. 74).

In a study by Borzecki and Wormith (1987), that evaluated both Canadian and American programmes, the measure of evaluation was how many adolescent sex offenders completed the treatment programmes. It was found that the completion rates ranged from 90% to 67%. The only mention made of recidivism rates was that they were low.

A study by Graves, Openshaw, and Adams (1992), measured the acquisition of social skills after involvement in the ASSET programme. The definition of social skills training was "the enhancement of congruent verbal and nonverbal interpersonal communications and the facilitation of a mutually satisfying relationship with others" (p. 141). In comparison to a control group, the experimental group was found to have acquired eight ASSET skills. It was

found that parental communication had improved for the experimental group, but that problem solving did not improve.

Covert sensitization, satiation therapy, individual psychotherapy, attendance in school, and family therapy were used in a programme evaluated by Hunter and Santos (1990). The outcome instrument used was the plethysmograph to measure the increase in non-deviant sexual arousal, and a change in aggressive to non-aggressive cues. It was found that there was about a 25% increase to non-deviant sex arousal cues, a 37% decrease in arousal to non-aggressive sexual activity with a same age prepubescent male, a 42% decrease in aggressive sexual activity with a prepubescent male, and a 7% increase in consensual sexual activity with a female.

Research Conclusions

As discussed in the beginning of the thesis, there are many articles that describe the types of treatment programmes currently being used in North America. One limitation of most of these articles is that they have not completed research on outcome measures to determine whether the programme has been a "success" or "failure". Bremer (1992) states that "in order to develop programs that contain enough [programme components], but not too much, we must first investigate the results of all attempts at intervention, including those we consider a failure" (p. 330). This research needs to be conducted before the proliferation of these programmes continues.

Most of the programmes described above fall under the domain of a cognitive-behavioural treatment category. This area is also where the majority of the outcome research has been conducted. The general conclusion of the articles on recidivism research has been that the

recidivism rate for sex crimes is around 10% per programme (Davis & Leitenberg, 1987). The recidivism rates from the articles reviewed were reduced to about 10-15%. There was a low rate of 2.5% to the highest rate of 34%. The recidivating group is the high risk sex offenders who, it would appear, could benefit the most from transitional support programming, and post-treatment support groups. Bremer (1992), related recidivism rate to length at risk prior to recidivating (amount of time out of the programme before committing a new offence) and concluded that length at risk "suggests that reoffending may be related to specific stressful events in a individual's life that are unpredictable" (p.331). She then states that it is necessary to incorporate an educational component to the programme in order to identify stressors in the offender's life.

Davis and Leitenberg (1987), have argued that recidivism is not the best measure of success of the programmes because it does not include the adolescents who have committed new crimes and never been caught. The recidivism rate approach, also does not include sexual abusers brought to the authority's attention, but who are dealt with in a nonlegal method. Recidivism rates, therefore, are likely to underestimate the rate of sexual offending. The reason for its use is that it is one of the easiest and most convenient methods to employ in research, and it allows for easy replication of the study. It has also been represented as the ultimate goal of the programmes, that is, to protect society by stopping these adolescent sex offenders from hurting more victims.

The other outcome measures research have also focused exclusively on cognitive-behavioural treatments. The outcome measures used have included self-reports on level of arousal, reports on social competence, examination of completion rates, and tests of attitudes

and knowledge. Self-reports by the adolescents may contain many errors. The adolescents do not want to be sent back to a detention facility, nor to a treatment facility, therefore, they are likely to cover-up any new sexual abuse that they have committed. On the other hand, the self-report studies may give us more information, since it will include adolescents other than just the ones charged with new sex crimes. Problems with the tests used to examine attitudes and knowledge may contain many flaws as well. There are problems with the validity and reliability of such tests that must be examined.

The overall findings from the "other" programme outcome studies seem to indicate that arousal level decreases towards both aggressive and deviant scenarios, and that sexual knowledge increased after the treatment programme.

Conclusion

Most treatment facilities treating adolescent sex offenders appear to employ more than one method of treatment. There is usually a combination of cognitive-behavioural, relapse prevention, self-help programmes, and some other method of treatment. The current mode of thought, though, is in emphasizing cognitive-behavioural methods that focus on reducing deviant sexual arousal. Although the preliminary research data indicate that though there is a reduction in official recidivism rates and in deviant sexual arousal, no approach can guarantee success. More research must be conducted on the various types of programmes currently being utilized. It may be found that certain programmes suit certain types of sex offenders better than other programmes, which should facilitate the decrease of the reoffence rate. Until this research is conducted, therapists and clinicians will continue to employ these same

treatment methods over and over, and the elimination of inefficacious treatment programmes will not occur.

Chapter 5 - Methodology and Results

Methodology

Subjects.

The research was conducted on four different treatment groups (total n=72). Two groups included adolescent sex offenders in two rural towns in British Columbia (Programmes 1 and 2). There were 13 subjects from programme 1, and 8 subjects from programme 2. The subjects in these groups were all living within the vicinity of the treatment programmes. The two groups (Programmes 3 and 4) in the urban settings included youth who were from the area. Programme 3 also included youth who were from other areas of British Columbia than the immediate vicinity of the programme. There were 21 subjects from programme 3, and 30 subjects from programme 4. The mean age of the subjects was 14.6 years. Most were in grade 10 or less (85%). All subjects were male.

Programmes.

Treatment programme 1 is an outpatient programme. The adolescents live in the community, and attend sex offender group therapy once a week. They may also be required to attend individual therapy and family therapy. These youth attend school in the community. Most of the adolescents admitted have been adjudicated through the Young Offenders System, and all are required to show some type of admittance to having committed the crime. Treatment programme 2 is a residential attendance programme. The youth live together in a residential setting where they attend school, and take part in other vocational, and recreational activities. These youth also attend sex offender group therapy, along with, individual and family therapy. Youth admitted to the residential programme have also been adjudicated by

the courts, and they must also show some admittance to having committed the crime. These youth are judged to need more structure in their lives than the adolescents admitted into programme 1. The youth in the residential programme are under twenty-four hour supervision. The rationale is that the structure decreases the chaos and confusion the adolescents may have experienced, and introduces a routine into their lives. In the residential setting they may also be required to attend other types of therapy or groups that are offered at the facility. Both the residential and the community treatment programmes include social skills training, sex education, cognitive restructuring, victim empathy, accountability therapy, covert sensitization, satiation therapy, and relapse prevention. In family and individual therapy the staff also employ narrative therapy and psychological therapies, including psychoanalysis. The adolescents in both of these programmes are required to attend group therapy once a week.

The third programme is a residential programme that provides life skills and living skills learning experiences. The offenders in this programme are also required to attend therapy at the programme 4 treatment facilities. The adolescents are under twenty-four hour supervision. This programme provides schooling, and employment skills, as well as recreation and key living and lifeskills. The youth admitted to this programme have difficulties stemming from a paraphilia disorder.

The sex offender treatment programme 4 employs covert sensitization, satiation, sex education, cognitive restructuring, social skills, victim empathy, relapse prevention, and an examination of the heroes, and fantasies of the adolescents. These techniques are used in group therapy. The youth may also be required to attend individual and family therapy. The

individual therapists use various techniques based on his/her own background and training. The adolescents are required to attend group therapy once a week.

Procedure.

All of the information collected on the adolescent offenders was done through their files at each of these treatment programmes, respectively. Each of these files included the police report, the probation order, pre-disposition report, Youth Court Services Intake Summary, therapists' notes, and various intake forms specially designed for each programme. Programmes 1 and 2 included a client referral form, an adolescent intake form, a parent/guardian intake inform, and a referral form. Programme 3 includes a general file, a confidential file, and a case management file. The general file includes basic demographic information, the confidential file includes the pre-disposition report, a psychological assessment, and the police report. The case management file includes "monthly or bi-weekly progress reports on the offenders" (Kucy, 1995, p. 68). The fourth treatment programme includes the basic files previously mentioned, plus an intake form which summarizes demographic and paraphilia information. The cases for the first, second, and fourth programmes included adolescents who were in treatment between 1991 and 1994. The third programme included youth in treatment between 1987 and 1994.

The types of information collected were selected on the basis of previous articles and research on adolescent sex offenders. A coding sheet (see Appendix A) was developed to collect the information on each individual offender. Along with the coding sheet, a coding manual (see Appendix B) was produced in order to define each variable and to explain where

and how each variable was being collected. All of the information was collected directly from each of the offenders' files. No direct contact was made with the offenders or their families.

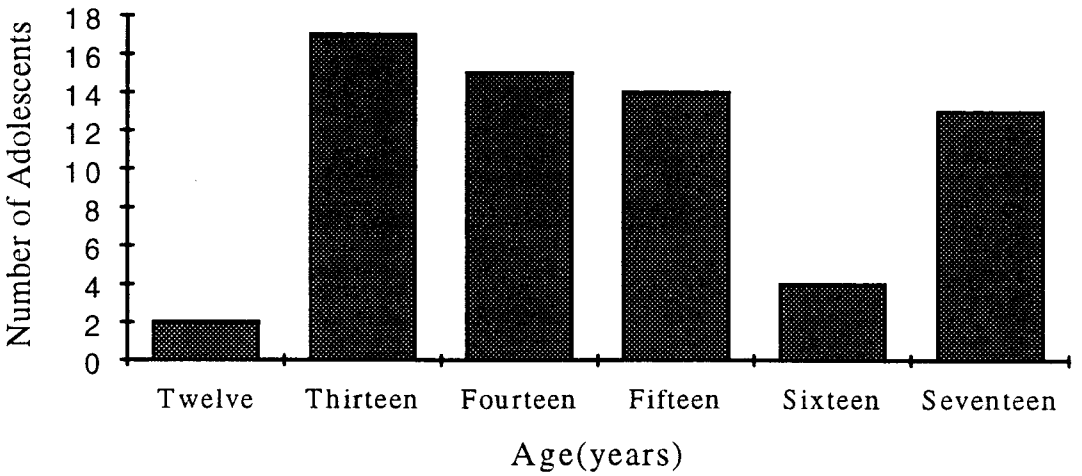
Results

Most of the results presented here are reported in totals, percentages, and means. There were also calculations completed to analyze any significant relationships among the groups. If the results showed a significant relationship among the different treatment groups on a variable, this was indicated. If no mention is made of the relationships among the groups, then there was no significant relationship found. The results are presented in the same order as was done in the background review on characteristics of adolescent sex offenders (see Chapter 2).

Age.

The age of the adolescent offenders was calculated by taking the difference between the date of the offence given in the reports, and the date of birth recorded on the intake referral forms. Most of the subjects were between the ages of twelve and fourteen years (52.3 %), inclusive, while the rest (47.7%) were between the ages of fifteen and eighteen years when they committed their present crime(s). The mean age was 14.6 years at the time of the present offence.

FIGURE 1: Age at Time of Offence.



As can be seen from the above chart, there were subjects in all the age groups covered by the Young Offenders Act; 12 year olds (2), 13 year olds (7), 14 year olds (15), 15 year olds (14), 16 year olds (4), and 17 year olds (13). There were seven subjects missing from this variable.

Ethnicity.

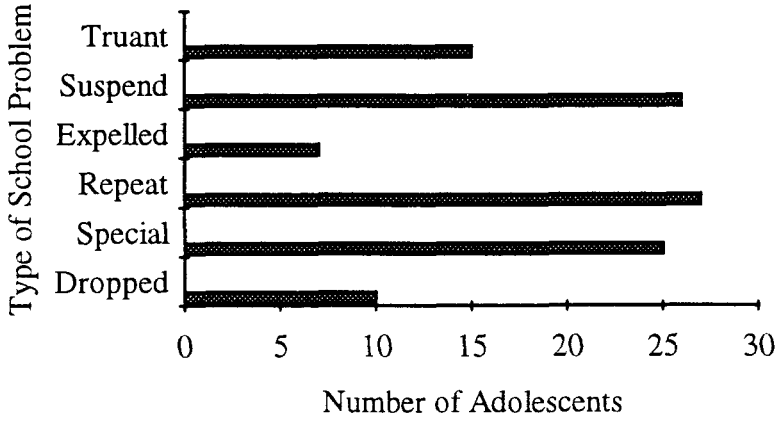
Exactly half of the subjects were reported as being Caucasian, 21% were recorded as being Aboriginal, and 8% were classified as "other" ethnicities.

Education.

The subjects were between grades six and twelve. Most of the subjects (64%) were in grade nine or less. There was a significant difference among the four treatment programmes and whether the adolescent repeated at least one school grade (X^2=10.5069, df=3, p<.01). Within programme 3, 11 of the 21 adolescents (52%) had repeated at least one grade, and within programme 2, 6 of the 8 adolescents (75%) had repeated at least one grade. In the other two programmes, the majority of adolescents had not repeated any grades. Overall, 38% of the adolescents had repeated at least one grade, 35% had been placed in special

classes, 14% had dropped out of school, 21% had been truant from school, 36% had been suspended from school at least once, and 10% had been previously expelled from school.

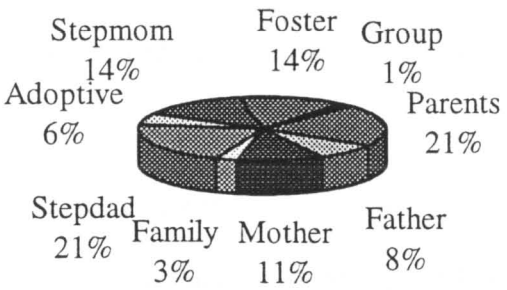
FIGURE 2: Subjects With School Problems.



Family Structure.

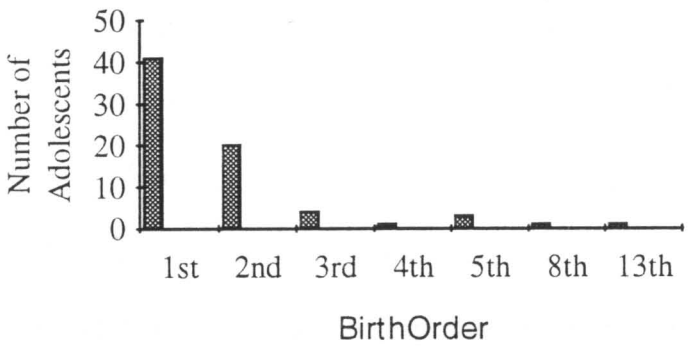
Less than a quarter (21%) of the adolescents lived with their natural parents at the time of committing the offence. Most subjects (35%) lived with one natural parent and one step/common-law parent. Eight percent lived with only their natural father, while 11% lived with only their natural mother. Six percent lived with adoptive parents, and the rest (28%) lived with foster parents, with other family members, or in a group home. Fifteen percent had a history of psychiatric intervention in their families.

FIGURE 3: Living Arrangements At Time Of Offence.



Most of the subjects (96%) had siblings. Only two subjects (4%) were only children. The term "siblings" includes biological, step and half brothers and sisters. Fifty-six percent of the subjects had one or two siblings. Thirty-eight percent had between three and seven siblings, and 3% had fourteen siblings. Fifty-seven percent of the subjects were the oldest sibling, followed by 28% who were second oldest sibling. Thirteen percent were between the third to the eighth oldest, and one subject was the thirteenth out of fourteen siblings.

FIGURE 4: Birth Order.



Physical and Mental Health Histories.

Seventy-three percent of the adolescents had experienced at least one of the conditions recorded under "Mental Health Variables". These "Mental Health Variables" included:

suicidal ideations, neurological insult, attention deficit disorder, enuresis, cruelty to animals, and fire setting. Fourteen percent of the subjects had reported having previous suicidal ideations, while only 7% had attempted suicide. Twenty percent were reported as having experienced neurological insult.

Substance Abuse.

Only 14% of the subjects were reported as having used both alcohol and drugs, while 27% used alcohol, and 20% reported having used drugs. Whether or not the adolescent offenders were using drugs or alcohol at the time of committing their offence, was not recorded.

Pornography.

Forty-seven percent of the subjects had been exposed to some type of pornographic material, and one-quarter were reported as having used pornography.

Past Abuse.

A significant relationship was found between treatment group and whether the subjects had been sexually abused (X^2=20.0775, df=2, p<.000). While the majority (71%) of the adolescents from programmes 1, 2, and 4 were not recorded as having been previously sexually abused, the third programme reported that 18 of the 21 subjects (86%) had been previously sexually abused.

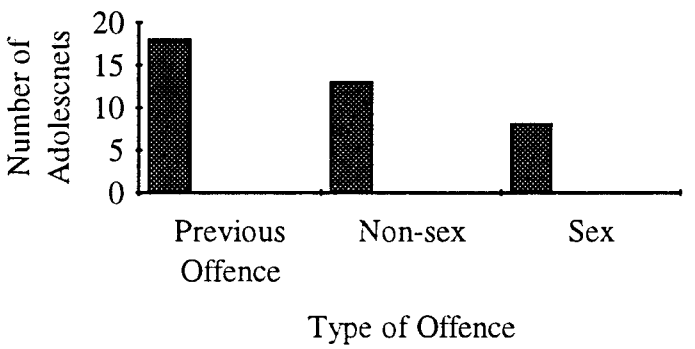
Forty-seven percent of the subjects had reported experiencing previous physical abuse, and 35% had experience previous psychological abuse. Overall, thirty-one of the subjects (43%) reported being previously sexually abused. Almost one-quarter of the sexually abused subjects (23%) were assaulted by a relative outside of their immediate family, 16% were abused by a sibling, and 10% were abused by their fathers. Sixteen percent were sexually

abused by a stranger, 6% by a school mate, and 26% were abused by "others" (i.e. an acquaintance of the family, family doctor). Ten percent (3) had unknown abusers. The most common type of abuse the subjects experienced was fondling of the genitals (23%), followed by anal intercourse (15%), and oral intercourse (15%). Most files on the subjects did not mention type of abuse (46%).

Past Offences.

One-quarter of the subjects had been convicted prior to the current offence. Of the subjects who had previous convictions, 72% of the subjects had committed non-sexual offences, and 44% (8) had committed sexual offences. 17% of the adolescents with prior convictions had committed both prior sexual and non-sexual offences.

FIGURE 5: Convictions for Previous Offences



Of the subjects who committed previous sexual offences, three-quarters (6) had been convicted of one sexual offence, and 25% (2) were convicted of two prior sexual offences.

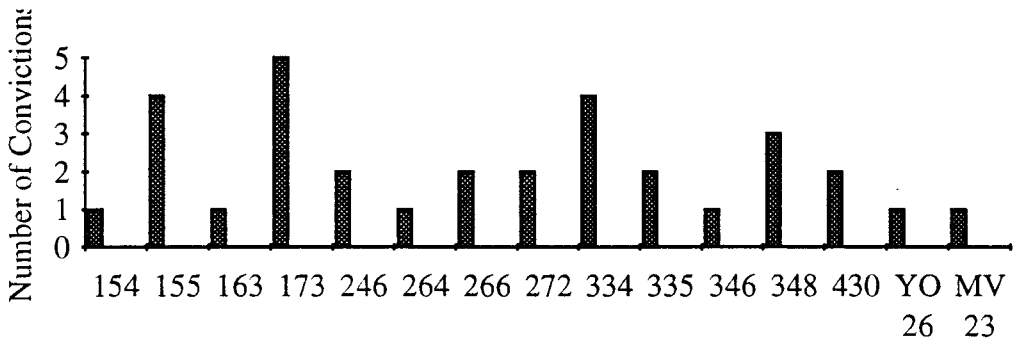
Sixty-one percent of the subjects who were convicted of prior offences had received a previous probation order. Of the eight subjects who had previous convictions for sexual offences, 63% received probation for this previous offence, one had an unknown outcome, and 2 were diverted. Only one of the subjects who had committed a previous sex offence

received sex offender treatment for that offence, the other seven had not received specialized sex offender treatment for their previous offence.

Present Offences.

In total, there were 125 convictions for 69 subjects, 3 subjects had unknown charges. Most of the convictions were under Criminal Code of Canada (CCC) section 271 (see Appendix C for the definitions of CCC sections), there were 18 convictions under CCC section 151, and nine convictions of CCC section 152. The rest of the convictions are summarized in the following graph.

FIGURE 6: Number of Convictions Under each Criminal Code Section (See Appendix C for definitions of section numbers).



Ninety-seven percent of the subjects received a sentence of probation for their most recent crimes. Three percent received probation and jail days. The length of probation ranged from 10 months to 36 months. The median probation length was 24 months. Most of the adolescents (90%) received a sentence of probation for 2 years or less.

TABLE 5: The Distribution of Length of Probation.

Length of Probation (Months)	Number of Subjects	Percentage of Subjects.
10	1	2%
12	4	7%
13	1	2%
15	2	3%
18	10	16%
21	1	2%
24	36	59%
36	6	10%

Victims' Characteristics.

The majority of offenders (92%) knew their victims prior to sexually assaulting them. The most common relation between the offender and victim was sibling (36%), followed by baby-sitting clients (17%). Ten percent of the victims were an "other relative" (i.e. cousin, niece, or nephew). Seven percent were school mates, 3% were foster children, and 7% were strangers.

Sixty-eight percent of the victims were below the age of 12 years. Only 6% were above 18 years of age. The median age of the victims was 7 years. Below is a distribution of the ages of the victims.

FIGURE 7: Victims' Ages.

Sixty-one percent of the subjects assaulted only female victims, while 18% sexually assaulted only male victims, and 14% abused both male and female victims. Most of the offences (21%) occurred within the victim's home, followed by the victim and offender's home (19%), and then the street (6%). The offences occurred 4% of the time in the offender's home, 4% in the school yard, 4% in the park, and 3% in another person's house (i.e. a mutual friend of the victim and offender).

Most of the offenders had one victim (58%), followed by two victims (28%). Three percent of the offenders had three victims, and 6% had 4 victims. One subject was reported as having no victims because he was caught stealing pornography from a store. As he had no direct human victims, this act was counted as having no victims.

Type of Power.

Thirty-three percent of the adolescents were not reported as using any visible type of coercion or force against their victims. Thirteen percent of the offenders used threats against their victims, 14% also used coercion in committing the offence, 7% used physical force against the victims, and 1% used a weapon.

Recidivism - Survival Analysis.

Overall, there were 65 reconvictions following the release from a treatment programme. Twenty of the subjects were reconvicted of committing crimes after release from the treatment programme. Most of the 20 adolescents were convicted for non-sexual offences (290%[6]). The most common conviction (55% of the 20 adolescents who recidivated) was for Breach of the Young Offenders Act. Seven of the subjects were reconvicted of sex offences following

[6] The percents add to over 100% because some of the adolescents had more than one reconviction. They were, therefore, included in the percentage of more than one offence type.

release from a treatment programme. Three of the subjects from programme 4, and 4 from programme 1 were reconvict for sex offences. A survival table was calculated comparing the four treatment programmes. The resulting graph can be seen below. Figure 8 shows the proportion of adolescents from each programme who were not convicted of any new serious offences (excludes Breaches of YOA, probation, recognizance, and Failure to Appear) over time, following release from treatment. Figure 9 is the proportion of adolescents from each programme who were not convicted on new sex offences.

FIGURE 8: Proportion of Adolescents Not Convicted on New Serious Offences

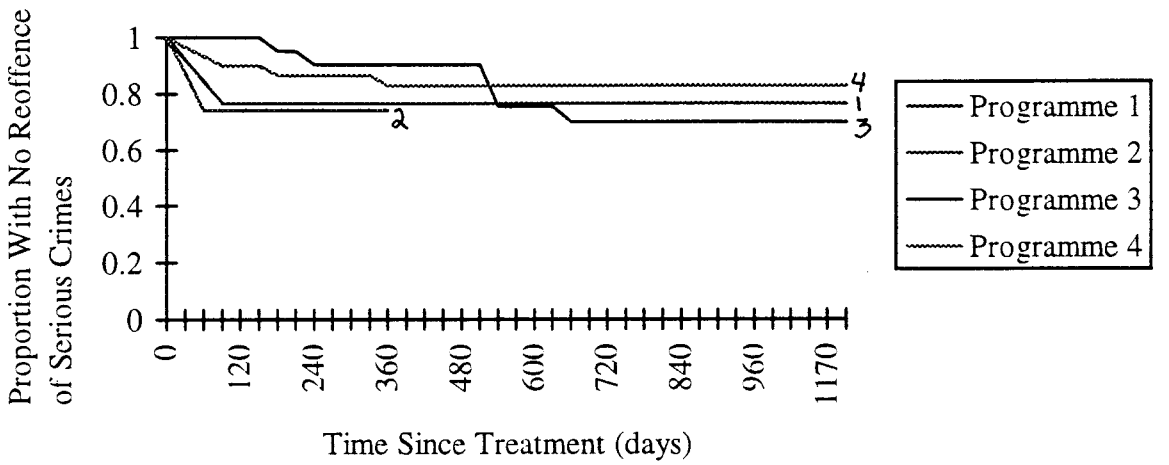


TABLE 6: Chart of Percentages Not Committing New Serious Offences.

Programme	Day 0	Day 30	Day 60	Day 90	Day 180	Day 240	Day 360	Day 540
1	100%	92%	84.6%	76.6%	76.6%	76.6%	76.6%	76.6%
2	100%	87.5%	74%	74%	74%	74%	74%	
3	100%	100%	100%	100%	95.2%	90.5%	90.5%	75.4%
4	100%	96.7%	93.3%	90%	86.7%	86.7%	82.8%	82.8%

FIGURE 9: Proportion of Adolescents Not Reconvicted of Any Sex Offences.

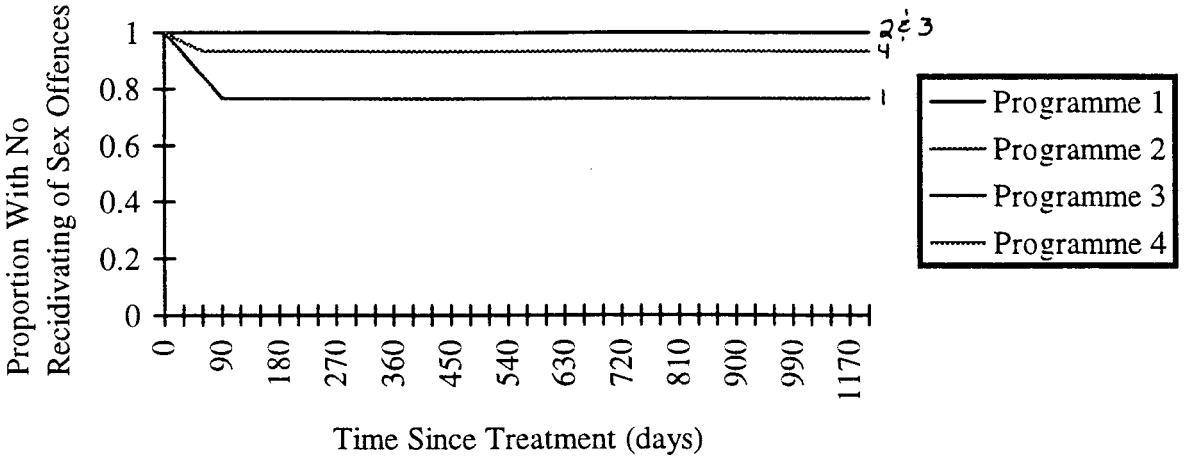


TABLE 7: Percentage of Adolescents Not Committing New Sex Offences.

Programme	Day 0	Day 30	Day 60	Day 90	Day 360
1	100%	92.3%	84.6%	76.6%	76.6%
2	100%	100%	100%	100%	100%
3	100%	100%	100%	100%	100%
4	100%	96.7%	93.3%	93.3%	93.3%

In calculating survival analysis, there are a few assumptions that must be taken into account. The first assumption is that "survival experience does not change" (SPSS: Advanced Statistics, 1990, p. 243) during the follow-up period after leaving treatment. This refers to systematic changes, not "random" individualized experiences. For instance, if, after the first year of follow-up, there was suddenly a directive that sex offenders report daily to a Probation Officer, obviously the "survival experience" of those cases followed after the policy change would differ from those prior to it. However, such a change in policy or directive was not known to have occurred. The second assumption is that sex offenders leaving treatment early in the study are similar to those leaving later in the study. If pedophiles became ineligible for treatment in favour of violent offenders at some point in the study, this would obviously be a

problem. Again, this type of change in treatment prioritization was not known to have occurred. The final assumption is that those who recidivate are not systematically different from those who do not in term of factors other than their recidivism.

Most of the adolescents who recidivated, began to do so within the first twelve months, and all of the adolescents who recidivated began to do so within 2 years of release from a treatment programme.

Most of the 20 adolescents were convicted for non-sexual offences (290%[6]). The most common conviction (55% of the 20 adolescents who recidivated) was for Breach of the Young Offenders Act. Convictions for sexual assault, sexual assault with a weapon, sexual assault with a female under 14 years of age, and incest consisted of 11% of the offences. The rest of the convictions are summarized below.

[6] The percents add to over 100% because some of the adolescents had more than one reconviction. They were, therefore, included in the percentage of more than one offence type.

TABLE 8: Convictions of Reoffences.

Category	Count	Percent of the Cases	Percent of Offences
Sexual Assault	2	10%	3%
Sexual Assault with a weapon	1	5%	1.5%
Sex with a Female < 14	3	15%	4.6%
Theft under $1000	6	30%	9%
Theft over $1000	2	10%	3%
Possession of Stolen Property	8	40%	12%
Break and Enter	7	35%	10.7%
Possession of a Break & Enter Instrument	1	5%	1.5%
Mischief & Willful Damage	4	20%	6%
Incest	1	5%	1.5%
Breach of the YOA	11	55%	17%
Breach of Probation	2	10%	3%
Motor Vehicle Offence	2	10%	3%
Escape/At large	3	15%	4.6%
Assault	3	15%	4.6%
Robbery	3	15%	4.6%
Failure to Appear	2	10%	3%
Resisting & Obstructing a Peace Officer	1	5%	1.5%
Intimidation	1	5%	1.5%
Use/Possession of Weapon	1	5%	1.5%
Breach of Recognizance	1	5%	1.5%
TOTALS	65	325%[7]	99%[8]

The majority of the adolescents who recidivated were convicted of two or more charges (60%). Twelve of the adolescents were convicted of 88% of the offences. Most of those multiple convictions occurred at more than one time (83%). The number of convictions ranged from one (n=6) to nine (n=1), with the mean number of convictions being 3.

[7] The percents add to over 100% because some of the adolescents had more than one reconviction. They were, therefore, included in the percentage of more than one offence type.

[8] Does not add to 100% due to rounding.

Chapter 6 - Discussion

Following from the earlier theoretical perspectives discussed, the treatment techniques actually employed in the programming, and outlined from the prior literature, this chapter will examine the present findings and attempt to draw conclusions and make meaning of the results. In Chapter 1 there were three main problems presented, each of these will be reviewed in the following section. The problems focused on the underlying theories and assumptions each treatment programme utilized, on the demographic profiles of the adolescent sex offenders in these programmes, and on the outcome measure of the programmes.

Differences in the Theoretical Approach Employed

The first of the three main hypotheses was about the theories which drove each of the treatment programmes, and if they differed from each other in some important way. Following from the programme descriptions given in the previous section (Chapter 5), it can be seen that the main focus for all four treatment programmes is on cognitive-behavioural treatment components. These cognitive-behavioural components are derived from social learning theory. Since, social learning theory suggests that deviant sexual behaviour is mostly a learned phenomenon, the main focus of the cognitive-behavioural treatment techniques is for learning of new behaviour to occur to override the previously learned deviant behaviour. All four of the programmes included at least some of the different techniques from the cognitive-behavioural approach, with all four programmes also including varying amounts of the psychodynamic, and other theoretical approaches.

Since, the main focus of all of the programmes was on cognitive-behavioural treatment components, it can be stated that they, therefore, did not differ significantly in their primary theoretical approaches employed, nor in the underlying assumptions they followed.

Characteristics of the Adolescents in the Four Programmes

Each of these variables will be considered and compared to the discussion in the prior literature on that variable. Similar to the mean age of the adolescent offenders in previous studies, this study found a mean age at the time of the most recent offence close to 15 years. This present research found that over 50% of the adolescents were Caucasian. Because previous research was conducted in the United States, which has different composition of ethnic groups from those in Canada, there is no direct way to make a comparison.

Similar to Jackson's (1987) study, this research found that the majority of the adolescents had completed grade nine or less. Along with over a quarter who were in special education classes, over half of the adolescent offenders had been truant, suspended or expelled. This would indicate that they tend to have complications in adjusting to a school environment. Much the same as previous studies have reported on "family instability", here it was found that a majority of the adolescents had lived with more than one caregiver. These adolescents were more likely to live with only one natural parent, than with both of their natural parents. This supports the previous research on this variable. As well, it is consistent with sociobiological theories that emphasize the significance of kin relationships in criminality (Daly and Wilson, 1985). Almost all of the adolescents had at least one sibling. Unlike Awad et al. (1984), the adolescents came from families with 1 to 2 siblings. The mean number of siblings found here supports Oliver et al. (1993), in that the families were small.

Unlike Van Ness (1984), and Hunter and Becker (1994), there was less than one-third of the adolescents who had problems with either alcohol or drugs. The findings were closer to Kahn and Chamber's (1991) findings of 37% having a problem with alcohol or drugs. Unlike Hunter and Becker (1994), very few adolescent sex offenders in the study used pornography, but a majority of the adolescents were found to have been previously exposed to pornography. Since the question was divided into use and exposure to pornography, this provides more detail on where the adolescents had been exposed to sexual ideas and actions. One possibility then is that pornography is where the adolescents get the ideation to sexually abuse someone.

The findings on previous sexual, physical, and psychological abuse fell in the middle of the findings from previous studies. Each of the types of abuse occurred to about half of the subjects. The previous research findings tended to be at either extreme, either around 80% or less than 20%. Unlike the previous research, most of the adolescents in this study did not have previous convictions. This variable marked the most striking difference between previous studies and this research. The previous research indicated that at least half of the subjects had committed previous offences, but the current study found that only a quarter had previous convictions. One of the most surprising findings of this research was that of the eight adolescents convicted of previous sex offences, only one of the eight had attended specialized sex offender treatment for that previous sex offence. It took a second offence to occur before these subjects attended a sex offender treatment programme.

Following from the previous research, this study also found that the majority of the victims were female, known to the offender, and were younger than the offender. Where the offenders' mean age was just below 15 years of age, the victims' mean age was 9 years. The

offence was also likely to occur someplace where the victim felt comfortable and was not going to be suspicious of the potential offender the first time the offence occurred. Most of the offences also took place inside someone's home, this is a much easier place to hide the abuse - behind four walls and a closed door, than in the street or park.

The present study found a slightly smaller percentage of offenders employed any type of overt power over their victims, than the past research had indicated. The only time a weapon was used was with a victim older than the offender. Most of the power the offender used was described as a covert and not an overt type of power or coercion. The offender was most likely to be in a position of trust and authority (i.e. baby-sitting), and was also more likely to be of a larger physical size, due to being male and older than most of the victims. A number of the results of the demographic variables were similar to the conclusions reached by previous studies.

Significant Differences in the Characteristics

There were two significant differences among the adolescents of the four treatment groups. These were noted for the adolescents who had repeated at least one school grade, and for those experiencing sexual abuse. Where the majority of the adolescents from programme 1 and programme 4 had not repeated grades, most of the youth from programme 2 and programme 3 had repeated at least one school grade. More importantly, the files from programme 4 , and both programmes 1 and 2, indicated that the majority of the adolescents had not been previously sexually abused, whereas, most of the adolescents from programme 3 indicated that they had been previously sexually abused. Since, the majority of the adolescents from programme 3 had repeated grades and had also been sexually abused, this is an

indication that the adolescents from the third programme had more "troubled" histories. This is an interesting note, considering that the third programme had the second lowest overall recidivism rate, especially since the literature (i.e. cognitive-behavioural) claims that previous sexual abuse might serve as a prime learning background for future sex offending. If prior sexual abuse leads to increased thoughts of deviant behaviour and a greater chance to learn and pair the abuse with pleasure it is speculated that the adolescents attending programme 3 have experienced more problems, and, as a result they would be more difficult to treat. This was not supported from the findings. Two possibilities exist to attempt to explain this occurrence. The first explanation is that the variable of prior sexual abuse may not have as much bearing on sexual offending behaviour as was previously thought. It may be necessary for other factors to be present, along with prior sexual abuse, for the occurrence of the offence to take place, and to make the offender more difficult to handle than another adolescent with different problems. The second possibility is that the adolescents may be more difficult to treat, but that programme 3 has been better able to handle and treat these adolescents. Since, all four treatment programmes contain similar cognitive-behavioural treatment techniques, especially lifeskills training, the third programme appears not differ significantly from the other programmes. If the third programme is not different, but the adolescents were more difficult, than it may have been the individuals' differences in their willingness to change, or the residential component of the third programme, that assisted these adolescents to curb their offending (this is discussed further below).

Since there were only two significant differences among the four treatment programmes for offenders characteristics, the answer to the question of whether the adolescents are similar

in demographic profile in the different programmes appears to be, "yes". The next question is whether these two major differences could alone indicate a significant difference among the programmes. The difference on repeating grades in school is not a primary variable mentioned in the prior literature, nor was it thought to be a measure of the differences among the programmes. The original intention was to use it in combination with the other school variables to give an overall idea of their ability in school, as well as their social skills ability. As mentioned above, the prior sex abuse was singled out to have occurred more to one group than the other three groups. The high number of adolescents experiencing this variable did not appear to impact the recidivism rate of the third programme, as this programme did not have any known reconvictions for sexual offences. Yet, the first and fourth programme which did have reconvictions for sexual offences had a lower rate of reported prior sexual abuse.

The Important Measure of Recidivism

The calculated recidivism rates indicate that for the four programmes, most of the adolescents have not been convicted of more charges since being released from their respective programmes. The recidivism rates calculated here are greater than most of the previous recidivism research indicated. However, by examining the types of convictions post-treatment, it is shown that most of the convictions were not serious, but were instead violations of their probation sentence. Since there were only seven convictions for further sexual offences, this would seem to indicate that for the most part, the four treatment programmes deterred most officially reported sexually offending behaviour. As Sapp and Vaughn (1990) determined, the ideal goal of treatment is to eliminate deviant sexual behaviour, yet, the reality is that "the best they could hope for was to lengthen the time

between offenses and reduce the seriousness of the behavior" (p. 138). Since, all of the treatment programmes deterred at least two-thirds of the adolescents from recidivating, and there were so few adolescents who committed more sex offences, each of the treatment programmes could be described as having achieved the reality goal for the time period examined.

All of the sexual reconvictions were by adolescents from programme 1 or from programme 4. This strongly suggests that the residential component of the second and third treatment programmes may help to give extra guidance and support needed to stop the sexual reoffending. This is especially supported by examining programmes 1 and 2. These treatment programmes contained the same components, and followed along the same lines, except that programme 2 was a residential programme. Yet, the two programmes had dramatic differences in the recidivism of sex offences, with programme 2 having none, and programme 1 having 4 convictions of 3 adolescents. The main factor deterring the sexual offending behaviour might be the close supervision and control of the adolescent's behaviour, plus the constant exposure to what are intended to be positive role models (staff), and the additional encouragement and support which is structured into the residential programme. Brannon and Troyer (1991), also indicate that the residential programme provides a safe climate for the adolescent to explore his behaviour, and to test his social behaviour, to explore the role and legitimacy of authority, how to be an individual and the atmosphere helps to reinforce the need to help others. The problem with this interpretation, comes from the results of the fourth programme, a non-residential programme, which obtained the lowest overall recidivism rate. However, given the offending behaviour primarily targeted, that is, sexual offending,

programme 4 can not be described as the most "successful", given that the reoffences were all sexual in nature. This would indicate that a closer examination again supports the idea of residential programmes providing the most beneficial atmosphere for treating adolescent sex offenders. There were no reconvictions for sex offences, which is the behaviour presently being studied, for programmes 2 and 3, which were residential programmes, but there were in programmes 1 and 4, which were community based programmes. Even though, the adolescents may have committed other offences, the most serious reconvictions were the sexual assaults.

The majority of adolescents in each of the four treatment programmes were not convicted on any further charges following release from treatment, and all four treatment programmes included at least some cognitive-behavioural components. Annis (1982), concluded that "a multimodal approach appears a strength of the treatment program" (p. 234). This statement appears to be supported by the present research. Each part of the treatment approach addresses a different side of the same problem, and each approach has a different goal. By combining these different approaches, more comprehensive treatment is achieved than if only one is employed. Finally, the residential supervision component combined with the cognitive-behavioural components, appears to lead to relatively successful outcomes for sex offender treatment programmes using those two elements.

There are a number of shortcomings with the current research that should be mentioned as they affect the generalizability of the research findings. There were the assumptions from the various theoretical approaches mentioned in Chapter 3, but by including programmes which

subscribe to these theories, it has been assumed that all of the assumptions underlying the programmes have been met, and are possible.

There is the problem of whether the low number of subjects in the study distorts the final findings and conclusions. While the current research begins to provide a glimpse into the various treatment programmes and their outcomes in Canada, especially British Columbia, further research is needed to confirm the findings presented here. The variable of prior sexual abuse was coded from the information provided in each of the adolescent's files. This information was included in the file if the adolescent had reported experiencing previous sexual abuse. Some of the adolescents may have experienced sexual abuse, but were not willing to discuss its occurrence, and, therefore they were not coded as having experienced sexual abuse. Becker and Kaplan (1988), stated that the adolescents may be reluctant to share their own histories of abuse in the initial interviews, since the abuse is more recent than an adult's, and the adolescent is uncomfortable in disclosing this information. Becker, Cunningham-Rathner, and Kaplan (1987), suggested that "the offender will be more likely to disclose an accurate account of his deviant behavior with more frequent therapeutic contact, more rapport, and more trust in a confidential setting (p.443). A further examination of subsequent reports of their own abuse histories and also of other deviant behaviour would help to determine if the initial count of abuse is an accurate portrayal of the adolescents.

In the present research there was no control group of non-treated adolescent sex offenders, but there were appropriate comparison groups. Having four comparison groups studied does contribute more to the previous research which has tended to research only one treatment

programme at a time. There has, as of yet, been no ethically approved experimental study designed on adolescent sex offender programming, complete with a control group.

There were also problems in the study with the recording of the information from the files of the adolescents, as not every file contained every piece of information needed, nor was it all assembled similarly. As well, the recidivism rates were calculated from the British Columbia provincial records; not from Canada wide information. Since, the recidivism rates were calculated from such information, this would exclude any unreported crimes the adolescents may have committed, and only includes a select sample of the individual's possible criminal record Canada wide.

This current research did address all of the goals set out for the research in Chapter 1. It adds knowledge to the previous Canadian studies that have been conducted on adolescent sex offenders. It also uniquely employed comparison groups to examine the similarities and differences among the treatment programmes. The research went beyond mere description of the components of the treatment programme to examine not only the recidivism outcomes of the four differing treatment groups, but other significant differences among the programmes. This also established a data base of information on the characteristics of the adolescent sex offenders in these programmes and in the programmes themselves, in order that further research can be conducted on the programmes.

There are many issues which have arisen from the current research that needs to be further examined. Future research should include larger sample sizes to make more meaningful comparisons. As stated at the beginning of this research, each of the treatment programmes employed more than one theoretical perspective and more than one method of treatment.

Additional research is needed to examine each treatment technique separately, as it is intended by theory to operate, to determine if one technique is more beneficial to the adolescent sex offender than others. This would help to develop programmes that would contain enough, but not too many components for effective focused treatment outcomes. There is also a need for other measurements than recidivism to be used to examine the different programmes. A longer follow-up period, or multiple follow-ups, would also examine whether recidivism rates fluctuate over time.

In addition, there are many areas not directly devised from this research, which remain in need of studying. For example, most of the research on adolescent sex offenders has been on male sex offenders; this has resulted in a void of information in the comparison of male and female sex offenders, especially in the Canadian context. It is also unknown whether male and female sex offenders can proceed through group treatment successfully together, or whether separate programmes are required. Another area for study is the classification of the sex offenders into different types of sex offences. Such classification may help to determine if different treatment approaches are useful for different types of offenders. Finally, there is a need to examine the similarities and differences among "normal" adolescents, non-sexual adolescent offenders, and sexual adolescent offenders, in order to establish similarities and differences among the adolescents.

Overall, the recidivism rates were low. Since, most of the reconvictions were for less serious offences, and only 35% of the cases of reconvictions were for sex offences, this supports the idea that the treatment programmes did at least suspend the sexual offending behaviour for the most part, and did decrease the seriousness of the crimes. Decreasing the

number of offences assists in the protection of society. The relatively low recidivism rates found in this study also have implications for programme and policy development. It would be of interest, for example, to further explore differences between residential treatment programming with community based programming. While corrections mandate is for more community treatment of offenders, with this particular group of young offenders, i.e. sex offenders, the greater structuring and maintaining afforded by residential centres may be a preferable approach. Consistent and constant treatment modalities, on an around-the-clock application, may provide the treatment intensity required. While this can result in greater restrictions on the youth's freedom in the short-term, through greater "social control", it might result ultimately in longer term freedom for the youth, if the intensive treatment "works". In any case, the examination and evaluation of the two approaches should be undertaken more systematically.

Finally, it is felt that it would be beneficial for the various treatment programme representatives to interact and discuss the programme components, and exchange ideas that may assist each group to provide more efficient and effective treatment for the adolescents. More research in this area can only help to determine the best way to treat adolescent sex offenders, and to stop this serious, hurtful behaviour.

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APPENDICES

Appendix A

Sex Offender Programme Data Sheet

Demographics

1. Coding Number (999=NA)	___	(1-3)
2. Youth Court Number (9999=NA)	____	(4-7)
3A. Year Admitted Into Programme (99=NA)	__	(8-9)
3B. Month Admitted Into Programme (99=NA)	__	(10-11)
3C. Day Admitted Into Programme (99=NA)	__	(12-13)
4A. Year Released From Programme (99=NA)	__	(14-15)
4B. Month Released From Programme (99=NA)	__	(16-17)
4C. Day Released From Programme (99=NA)	__	(18-19)
5A. Year of Birth (99=NA)	__	(20-21)
5B. Month of Birth (99=NA)	__	(22-23)
5C. Day of Birth (99=NA)	__	(24-25)

6. Place of Birth

1=British Columbia	7=Central/South America	__	(26-27)
2=Alberta	8=Australia		
3=Quebec	9=Manitoba		
4=Saskatchewan	10=Ontario		
5=United States	11=New Brunswick		
6=Europe	99=NA		

7. Racial Origin		_	(28)
1=Caucasian	4=Other		
2=Native	9=NA		
3=Hispanic			
8. Employment	0=No 1=Yes 9=NA	_	(29)

9. Longest Held Employment (In Months) (99=NA) __ __ (30-31)

Educational History

10. Last Grade Completed (99=NA) __ __ (32-33)

11. Truancy 0=No 1=Yes 9=NA __ (34)

12. Suspended 0=No 1=Yes 9=NA __ (35)

13. Expelled 0=No 1=Yes 9=NA __ (36)

14. Repeated Grade 0=No 1=Yes 9=NA __ (37)

15. Special Classes 0=No 1=Yes 9=NA __ (38)

16. Dropped Out 0=No 1=Yes 9=NA __ (39)

Family History

17. Living Arrangements at the Time of the Offence(s) __ __ (40-41)

1=Natural Parents
2=Natural Father Alone
3=Step/Common-Law Father and Natural Mother
4=Step/Common-Law Father Alone
5=Natural Mother Alone
6=Step/Common-Law Mother and Natural Father
7=Step/Common-Law Mother Alone
8=Adoptive Parents
9=Foster Parents
10=Grandparents
11=Other Family Members
12=Friend's Home, Peer, or Adult
13=Boarding or Group Home
14=Institution
15=Independent Living
99=Not Available

18. Group Home Placement Ever 0=No 1=Yes 9=NA __ (42)

19. Foster Home Placement Ever 0=No 1=Yes 9=NA __ (43)

20. Adopted Ever 0=No 1=Yes 9=NA __ (44)

21. Lived With Different Caregivers Ever 0=No 1=Yes 9=NA __ (45)

22. Ward of the Court Ever 0=Non-ward 2=Ward 3=Temporary Ward 9=NA __ (46)

23. Mother's Occupation __ (47)

0=Unemployed 2=Blue Collar 9=NA
1=Homemaker 3=White Collar

24. Father's Occupation __ (48)

0=Unemployed 2=Blue Collar 9=NA
1=Homemaker 3=White Collar

25. Marital Status of Biological Parents At Time of Youth's Offence(s)__ __(49-50)

1=Single 6=Separated
2=Married 7=Unknown
3=Common-Law 8=Both Deceased
4=Widowed 9=Annulled
5=Divorced 99=NA

26. Type of Relationship With Caregiving Mother __ (51)

1=Stable
2=Unstable
9=NA

27. Type of Relationship With Caregiving Father __ (52)

1=Stable
2=Unstable
9=NA

28. Type of Relationship With Biological Mother __ (53)

1=Stable 3=No Contact
2=Unstable 9=NA

29. Type of Relationship With Biological Father __ (54)

1=Stable 3=No Contact
2=Unstable 9=NA

30. Alcohol and/or Drug Abuse in Caregiving Family __ (55)

0=No Problem 3=Both
1=Alcohol 9=NA
2=Drugs

31. Prenatal Alcohol/Drug Use __ (56)

0=No Problem 3=Both
1=Alcohol 9=NA
2=Drugs

32. Physical Abuse in Caregiving Family 0=No 1=Yes 9=NA __ (57)

33. Sexual Abuse in Caregiving Family 0=No 1=Yes 9=NA __ (58)

34. Psychological Abuse in Caregiving Family 0=No 1=Yes 9=NA __ (59)

35. Criminal History of Caregiving Family 0=No 1=Yes 9=NA __ (60)

36. Psychiatric History of Biological Family 0=No 1=Yes 9=NA __ (61)

37. Siblings 0=No 1=Yes 9=NA __ (62)

38. How Many Biological Siblings (99=NA) __ __ (63-64)

39. How Many Step Siblings (99=NA) __ __ (65-66)

40. How Many Half-Siblings (99=NA) __ __ (67-68)

41. Order (Offender) (99=NA) __ __ (69-70)

Physical Health History

42. Physical Trauma 0=No 1=Yes 9=NA __ (71)

43. Medication Required 0=No 1=Yes 9=NA __ (72)

Mental Health History

44. Suicide Ideations 0=No 1=Yes 9=NA __ (73)

45. Suicide Attempts 0=No 1=Yes 9=NA __ (74)

45A. If yes, how many times (99=NA) __ __ (75-76)

46. Neurological Insult 0=No 1=Yes 9=NA __ (77)

47. Fire Setting 0=No 1=Yes 9=NA __ (78)

48. Abuse of Animals 0=No 1=Yes 9=NA __ (79)

49. Bed Wetting 0=No 1=Yes 9=NA __ (80)

50. History of Attention Deficit Disorder
0=No 1=Yes 9=NA __ (81)

Substance Abuse History

51. Alcohol Abuse 0=No 1=Yes 9=NA __ (82)

52. Drug Abuse 0=No 1=Yes 9=NA __ (83)

Miscellaneous

53. Exposure to Pornographic Material 0=No 1=Yes 9=NA __ (84)

54. Use of Pornographic Material 0=No 1=Yes 9=NA __ (85)

55. Early Exposure to Sexual Activity 0=No 1=Yes 9=NA __ (86)

56. History of Lying and/or Stealing __ (87)

0=Neither 3=Both
1=Lying 9=NA
2=Stealing

57. Any Previous Unofficially Reported Sex Abuse by Offender
0=No 1=Yes 9=NA __ (88)

Sexual Abuse History

58. Offender Sexually Abused 0=No 1=Yes 9=NA __ (89)

59. Age at Time of First Sexual Abuse Incident (99=NA) __ __ (90-91)

60. Length of Time Abuse Lasted __ (92)

1=One Incident 4=Years
2=A Few Incidents 9=NA
3=A Few Months

61. Abuser __ (93)

1=Sibling
2=Father
3=Other Relative
4=Babysitter
5=Stranger
6=School Mate
7=Other _____
9=NA

62. Place of Abuse __ (94)

0=None
1=Offender's Home
2=Victim's Home
3=Victim and Offender's Home
4=Public Place
5=Doctor's Office
9=NA

63. Type of Abuse

A. Exhibitionism	0=No 1=Yes	__	(95)
B. Voyeurism	0=No 1=Yes	__	(96)
C. Fondling Genitals	0=No 1=Yes	__	(97)
D. Digital Penetration	0=No 1=Yes	__	(98)
E. Anal Intercourse	0=No 1=Yes	__	(99)
F. Oral Intercourse	0=No 1=Yes	__	(100)
G. Other _____		__	(101)
H.	9=NA	__	(102)

64. Was Abuse Officially Reported Before Offender Charged With Current Offence? 0=No 1=Yes 9=NA __ (103)

<u>Past Offence History</u>

65. Previous Convictions 0=No 1=Yes 9=NA __ (104)

66. Type of Previous Offences __ (105)

0=None
1=Impaired Driving
2=Break & Enter
3=Possession of Stolen Property
4=Sex Offence
5=Theft
6=Robbery
7=Assault
8=Motor Vehicle
9=NA

67. Previous Sexual Offence Convictions 0=No 1=Yes 9=NA __ (106)

68. Number of Sexual Offences (99=NA) __ __ (107-108)

69. Age of Victims _____ __ __ (109-110)
(99=NA)

70. Sex of Victim(s) __ (111)

1=Male 3=Both
2=Female 9=NA

Dispositions

71. Probation 0=No 1=Yes 9=NA __ (112)

72. Length (months) (99=NA) __ __ (113-114)

73. Treatment Programme(s) 0=No 1=Yes 9=NA __ (115)

Current Offence

74. Adjudicated or Non-adjudicated __ (116)

1=Adjudicated 2=Non-adjudicated
9=NA

75. Agency Offender was Referred from __ (117)

1=Corrections 3=Other
2=Ministry of Social Services 9=NA

76. Legal Description of Offence(s) (999=NA) (Criminal Code Number and Description)

A. _____ __ __ __ (118-120)

B. _____ __ __ __ (121-123)

C. _____ __ __ __ (124-126)

77. Offender's Age at Time of Offence(s) (99=NA) __ __ (127-128)

78A. Year of Disposition (99=NA) __ __ (129-130)

78B. Month of Disposition (99=NA) __ __ (131-132)

78C. Day of Disposition (99=NA) __ __ (133-134)

79. Disposition of Offence __ (135)

0=None 2=Jail and Probation
1=Probation 9=NA

80. Probation Term (Months) (99=NA) __ __ (136-137)

General Description of Offence(s)

81. Location of Offence(s) __ (138)

1=Offender's Home 5=Park
2=Victim's Home 6=Street
3=Offender/Victim's Home 7=Acquaintance
4=School Yard 9=NA

82A. Year of Offence(s) (99=NA) __ __ (139-140)

82B. Month of Offence(s) (99=NA) __ __ (141-142)

82C. Day of Offence(s) (99=NA) __ __ (143-144)

83A. Until - Year of Offence(s) (99=NA) __ __ (145-146)

83B. Until - Month of Offence(s) (99=NA) __ __ (147-148)

83C. Until - Day of Offence(s) (99=NA) __ __ (149-150)

84. Type(s) of Power Used A. __ (151)
B. __ (152)

1=None 4=Physical Force
2=Threat 5=Weapon
3=Coercion 9=NA

85. Sexual Acts

A. Exhibitionism	0=No 1=Yes	__	(153)
B. Voyeurism	0=No 1=Yes	__	(154)
C. Fondling Breasts	0=No 1=Yes	__	(155)
D. Fondling Genitals	0=No 1=Yes	__	(156)
E. Assaultive Fondling	0=No 1=Yes	__	(157)
F. Digital Penetration	0=No 1=Yes	__	(158)
G. Anal Intercourse	0=No 1=Yes	__	(159)

CONTINUED ON NEXT PAGE

H. Oral Intercourse 0=No 1=Yes __ (160)
I. Vaginal Intercourse 0=No 1=Yes __ (161)
J. Bestiality 0=No 1=Yes __ (162)
K. Not Indicated 9=NA __ (163)

86. Duration of Offence(s) __ (164)

1=One Incident 4=Few Months
2=One Week 5=Years
3=Few Weeks 9=NA

87. Party Who Reported Offence(s) __ (165)

0=Victim 5=Offender
1=Victim's Guardian 6=Friend
2=Victim and Offender's Guardian 7=Other
3=Offender's Guardian 9=NA
4=Other Professional

Victim(s) Variables

88. Number of Victims (99=NA) __ __ (166-167)

89. Age of Victim or Age Range of Victims __ __ (168-169)
(At Time of Incident) (99=NA)

90. Gender __ (170)

1=Male 3=Both
2=Female 9=NA or Other

91. Relationship to Offender A. __ (171)
B. __ (172)

1= Sibling 5=Stranger
2=Other Relative 6=School Mate
3=Babysitting Client 7=Foster Child
4=Casual Acquaintance 8=Other _____
9=NA

Circumstances After the Sexual Offence(s)

92. Remorse/Empathy for Victim(s) 0=No 1=Yes 9=NA __ (173)

93. Victim(s) Received Therapy/Medical Care 0=No 1=Yes 9=NA __ (174)

94.Recidivism

0=No 1=Yes 9=NA __ (175)

95. Type of Recidivism

0=None
1=Sexual Assault
2=Sexual Assault with a Weapon
3=Sex with a Female Under 14
4=Theft Under
5=Theft Over
6=Possession of Stolen Propery
7=Break and Enter (B&E)
8=Possession of a B&E Instrument
9=Mischief and Wilfull Damage
10=Incest
11=Breach of the Young Offenders Act
12=Breach of Probation
13=Motor Vehicle Offence
14=Escape/At Large
15=Assault
16=Robbery
17=Failure to Appear
18=Resisting and Obstructing a Peace Officer
19=Intimidation
20=Use/possession of a Weapon
21=Breach of Recognizance
99=NA

A.__ __ (176-177)
B.__ __ (178-179)

Appendix B

Coding Manual for Evaluating Adolescent Sex Offender Programmes: A Pilot Project

Demographics

1. Coding Number

This number is given to each adolescent for the purpose of this study to ensure confidentiality. The first digit represents the place of treatment (1=Programme 1, 3=Programme 3, 5=Programme 3, 7=Programme 4), the second and third digits represent the personal identification of the client.
Obtain number from coding sheet.
If information is not indicated, Code 999 (NA).

2. Adolescent Court Number

This number was assigned to the adolescent when he appeared in court for the current charge(s). If the adolescent has appeared in court before and has numerous court numbers, the most current court number is used.
Obtain from intake information sheet or probation order.
If information is not indicated/not applicable, Code 9999 (NA).

3. A. B. C. Date admitted into Programme

The date (year, month, day) that the adolescent was admitted into the treatment programme.
Obtain information from client referral form.
If information is not indicated, Code 99 (NA).

4. A. B. C. Date released from Programme

The date (year, month, day) that the adolescent was released from the treatment programme.
Obtain information from Client referral form.
If information is not indicated, Code 99 (NA).

5. A. B. C. Date of Birth

The date of birth of the adolescent (year, month, day).
Obtain information from Client referral form, adolescent intake form, referral form, Adolescent Court Services intake form.
If information is not indicated, Code 99 (NA).

6. Place of Birth

The place of birth of the adolescent.
Obtain information from the referral form, and Pre-disposition report.
If information is not indicated, Code 99 (NA).

7. Racial Origin

The racial origin of the adolescent.
Obtain information from adolescent intake form.
If information is not indicated, Code 9 (NA).

8. Employment

Any history of paid employment.
Obtain information from adolescent intake form, and pre-disposition report.
If information is not indicated/not applicable, Code 9 (NA).

9. Longest Held Employment

The longest held employment by the adolescent coded in months.
Obtain information from adolescent intake form, and pre-disposition report.
If information is not indicated/not applicable, Code 99 (NA).

Educational History

10. Last Grade Completed

The last school grade completed by the adolescent at the time of his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 99 (NA).

11. Truancy

Truancy from any school system in adolescent's educational history before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

12. Suspended

Suspension from any school system in adolescent's educational history before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

13. Expelled

Expulsion from any school system in adolescent's educational history before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

14. Repeated Grade

Any grade(s) repeated in any school system by the adolescent before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

15. Special Classes

A special classes attended by the adolescent in a regular school system before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

16. Dropped Out

Whether the adolescent has ever dropped out of any school system before his admittance into the treatment programme.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

Family History

17. Living Arrangements at the Time of the Offence(s)

Where the adolescent was residing at the time of the offence(s).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

18. Group Home Placement Ever

Whether the adolescent was ever placed in a group home.
Obtain information from pre-disposition report, referral form, and adolescent intake form.
If information is not indicated, Code 9 (NA).

19. Foster Home Placement Ever

Whether the adolescent was ever placed in a foster home.
Obtain information from adolescent intake form, referral form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

20. Adoption Ever

Whether the adolescent was ever adopted by a family other than one involving his biological mother or biological father.
Obtain information from pre-disposition report, referral form, adolescent intake form.
If information is not indicated, Code 9 (NA).

21. Lived With Different Caregivers Ever

Whether the adolescent had lived with 2 or more caregivers before his admission to the treatment programme. "Different Caregivers" include different family members, different foster homes or group homes, and different adoptive families.
Obtain information from pre-disposition report, referral form, and adolescent intake form.
If information is not indicated, Code 9 (NA).

22. Ward of the Court Ever

The adolescent's legal status in the file being coded.
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

23. Mother's Occupation

The adolescent's caregiving mother's occupation at the time of coding the file.
Obtain information from pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

24. Father's Occupation

The adolescent's caregiving father's occupation at the time of coding the file.
Obtain information from pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

25. Marital status of biological parents at time of adolescent's offence(s)

The marital status of the adolescent's biological parents at the time the adolescent committed the offence(s).
Obtain information from adolescent intake form, and pre-disposition report.
If information is not indicated, Code 99 (NA).

26. Type of Relationship With Caregiving Mother

The type of relationship the adolescent had with his caregiving mother before admittance into the treatment programme. "Caregiving Mother" is defined as the mother the adolescent lived with at the time of the offence(s). "Stable" is defined as any indication in the file being coded that the adolescent and his caregiving mother got along with one another. "Unstable" is defined as any indication in the file being coded that the adolescent and his caregiving mother do not get along with one another.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

27. Type of Relationship with Caregiving Father

The type of relationship the adolescent had with his caregiving father before admittance into the treatment programme. "Caregiving Father" is defined as the father the adolescent lived with at the time of the offence(s). "Stable" is defined as any indication in the file being coded that the adolescent and his caregiving father got along with one another. "Unstable" is defined as any indication in the file being coded that the adolescent and his caregiving father do not get along with one another.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

28. Type of Relationship with the Biological Mother

The type of relationship the adolescent had with his biological mother before admittance into the treatment programme. "Biological Mother" may be the same as the Caregiving Mother (see above). "Stable" is defined as any indication in the file being coded that the adolescent and his biological mother got along with one another. "Unstable" is defined as any indication in the file being coded that the adolescent and his biological mother do not get along with one another.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

29. Type of Relationship with the Biological Father

The type of relationship the adolescent had with his biological father before admittance into the treatment programme. "Biological Father" may be the same person as the Caregiving Father (see above). "Stable" is defined as any indication in the file being coded that the adolescent and his biological father got along with one another. "Unstable" is defined as any indication in the file being coded that the adolescent and his biological father do not get along with one another.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

30. Alcohol and/or Drug Abuse in Caregiving Family

Past or present alcohol and/or drug abuse of any members in the adolescent's previous or current caregiving family (ies) (i.e. members in biological family, adoptive family and/or foster family).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

31. Prenatal Alcohol/Drug Use

Alcohol and/or drug use by the adolescent's mother during pregnancy.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

32. Physical Abuse in Caregiving Family

Past or present physical abuse within the caregiving family (ies) (i.e. biological family, adoptive family, foster family). The physical abuse may or may not involve the adolescent.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

33. Sexual Abuse in Caregiving Family

Past or present sexual abuse within the caregiving family (ies) (i.e. biological family, adoptive family, foster family) other than the adolescent.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

34. Psychological abuse in Caregiving Family

Past or present psychological abuse within the caregiving family (ies) (i.e. biological family, adoptive family, foster family) other than the adolescent.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

35. Criminal History of Caregiving Family

Past or present criminal offences committed by any member in the adolescent's previous or current caregiving family (i.e. members of biological family, adoptive family, foster family) regardless of whether or not that member was convicted.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

36. Psychiatric History of Biological Family

Past or present psychiatric/psychological problems in the biological family (biological father, mother, or siblings) demonstrated by a need for professional intervention (assessment, therapy, institutionalization).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

37. Siblings

How many siblings does the adolescent have at time of coding the file? "Siblings" includes biological, step and half sibling(s).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

38. How Many Biological Siblings

How many biological siblings does the adolescent have at time of coding the file (this excludes siblings that may have died).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

39. How Many Step Siblings

How many step siblings within the caregiving home does the adolescent have at time of coding the file.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

40. How Many Half Siblings

How many half siblings within the caregiving home does the adolescent have at time of coding the file.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

41. Order (Offender)

Including all siblings (biological, step, and half), the temporal order (from oldest to youngest = 1 to ?) of the adolescent.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

Physical Health History

42. Physical Trauma

Past or present injury (i.e. severe burns or accidents, and broken bones) which was not resulted from physical or sexual abuse, and was not a chronic disorder.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

43. Medication Required

Did the adolescent require medication at time of coding the file?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

Mental Health History

44. Suicide Ideations

Has the adolescent ever thought about committing suicide?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

45. Suicide Attempts

Has the adolescent ever attempted suicide?
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

45 A. If the answer to question #45 was yes, how many times did the adolescent attempt suicide?
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 99 (NA).

46. Neurological Insult

Past or present head injury suffered by the adolescent as a result of a severe impact (i.e. a fall resulting in unconsciousness).
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

47. Fire Setting

Past or present indication of adolescent setting fires at the time of coding the file.
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

48. Abuse or Animals

Past or present indication of adolescent abusing animals at the time of coding the file.
Obtain information from pre-disposition report, adolescent intake form and referral form.
If information is not indicated, Code 9 (NA).

49. Bed Wetting

Past or present indication of adolescent wetting his bed at the time of coding the file.
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

50. History of Attention Deficit Disorder

Descriptions of past or present attentional deficit disorder at the time of coding the file.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

Substance Abuse History

51. Alcohol Abuse

Past or present alcohol abuse by the adolescent at the time of coding the file.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

52. Drug Abuse

Past of present drug abuse by the adolescent at the time of coding the file.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

Miscellaneous

53. Exposure to Pornographic Material

Past or present exposure to pornographic material (i.e. magazines, videos).
Obtain information from pre-disposition report, adolescent intake form.
If information is not indicated, Code 9 (NA).

54. Use of Pornographic Material

Past or present use of pornographic material (i.e. magazines, videos).
Obtain information from pre-disposition report, adolescent intake form.
If information is not indicated, Code 9 (NA).

55. Early Exposure to Sexual Activity

This includes any sexual activity occurring before puberty, and excludes sexual abuse. Includes observational and/or involvement, intentionally or unintentionally exposure or introduction to sexual activity by an older individual (i.e. witnessing adults in sexual intercourse).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

56. History of Lying and/or Stealing

Past or present indication by anyone in the file of the adolescent lying and/or stealing.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

57. Any Previous Unofficially Reported Sex Abuse by Offender

Any admission by the offender or member of caregiving family that the offender has sexually abuse other victims without reporting the offences to the appropriate authorities.
Obtain information from pre-disposition report, adolescent intake form.
If information is not indicated, Code 9 (NA).

<u>Sexual Abuse History</u>

58. Offender Sexually Abused

Any report of sexual abuse by an older individual.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

59. Age at Time of First Sexual Abuse Incident

The adolescent's self report at what age (coded in years) he was first sexually abused.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 99 (NA).

60. Length of Time Abuse Lasted

The adolescent's self report on the length of time the abuse lasted.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

61. Abuser

The adolescent's self report on who the person who sexually abused him.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

62. Place of Abuse

The adolescent's self report of where the adolescent was sexually abused (i.e. park, adolescent's home, abuser's home, etc.)
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

63. Type of Abuse

What type of sexual abuse did the adolescent experience?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

64. Was Abuse Officially Reported Before Offender Charged With Current Offence?

Was the sexual abuse reported by the adolescent or another party to authorities before the adolescent was charged with most current offence?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

Past Offence History

65. Previous Convictions

Has the adolescent committed any other offences before committing the most current offence?
Obtain information from pre-disposition report, and referral form.
If information is not indicated/not applicable, Code 9 (NA).

66. Type of Previous Offences

The type of previous offences committed by the adolescent, coded according to description of offence.
Obtain information from pre-disposition report, and referral form.
If information is not indicated/not applicable, Code 9 (NA).

67. Previous Sexual Offence Convictions

Does the adolescent have any previous sex related offence convictions?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated/not applicable, Code 9 (NA).

68. Number of Sexual Offences

How many previous sex offences was the adolescent convicted of (excludes current sex related offence(s))?
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated/not applicable, Code 99 (NA).

69. Age of Victims

The age of the adolescent's previous victim(s) who he sexually abused.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated/not applicable, Code 99 (NA).

70. Sex of Victim(s)

The sex of the adolescent's previous victim(s).
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated/not applicable, Code 9 (NA).

Dispositions

71. Probation

Did the adolescent receive probation as a sentence for his previous sex related offence(s)?
Obtain information from pre-disposition report, and referral form.
If information is not indicated, Code 9 (NA).

72. Length

The length of the previous probation period coded in months
Obtain information from pre-disposition report, and referral form.
If information is not indicated/not applicable, Code 99 (NA).

73. Treatment Programme(s)

Was the adolescent involved in any treatment programme(s) as part of his probation order?
Obtain information from pre-disposition report, adolescent intake form, client referral form, and referral form.
If information is not indicated/not applicable, Code 9 (NA).

Current Offence

74. Adjudicated or Non-adjudicated

Whether the adolescent was charged, convicted, and sentenced on the current sexual abuse or whether the adolescent was known or suspected (i.e. through Social Services, etc.) of having committed the current sexual abuse.
Obtain information from pre-disposition report, adolescent intake form, and referral form.
If information is not indicated, Code 9 (NA).

75. Agency Offender was Referred from

Whether the adolescent was referred to the treatment programme from Corrections, Ministry of Social Services, or another agency.
Obtain information from pre-disposition report, adolescent intake form, client referral form, and YCS intake summary (if adjudicated).
If information is not indicated/not applicable, Code 9 (NA).

76. A. B. C. Legal Description of Offence(s)

The 1994 Criminal Code number of the offence(s) and the description of the offence.
Obtain from police report, referral form, pre-disposition report, probation order, and YCS intake summary.
If information is not indicated/not applicable, Code 999 (NA).

77. Offender's Age at Time of Offence(s)

The adolescent's age at the time he committed the offence(s).
Obtain from subtracting the offence date from the adolescent's birth date, or from pre-disposition report, YCS intake summary.
If information is not indicated, Code 99 (NA).

78. A. B. C. Date of Disposition (year, month, day)

The date the adolescent was given his disposition by the court.
Obtain from probation order.
If information is not indicated/not applicable, Code 99 (NA).

79. Disposition of Offence

The type of sentence the adolescent received.
Obtain from client referral form, adolescent intake form, referral form, probation order, and YCS intake summary.
If information is not indicated/not applicable, Code 9 (NA).

80. Probation Term

The length of probation term the adolescent received in months.
Obtain from client referral form, adolescent intake form, referral form, probation order, and YCS intake summary.
If information is not indicated/not applicable, Code 99 (NA).

General Description of Offence(s)

81. Location of Offence(s)

The location where the offence(s) occurred.
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

82 A. B. C. and 83. A. B. C. Date of Offence(s)

The date the offence(s) occurred.
Obtain from police report, pre-disposition report, probation order, and adolescent intake form.
If information is not indicated, Code 99 (NA).

84. Type(s) of Power Used

The type(s) of power used by the adolescent towards his victim(s).
Obtain from adolescent intake form, police report, and predisposition report.
If information is not indicated, Code 9 (NA).

85. Sexual Acts

The type(s) of sexual acts performed as specified in coding sheet.
Obtain from adolescent intake form, police report, and pre-disposition report.
If information is not indicated, Code 9 (NA) for K.

86. Duration of Offence(s)

How long did the offence(s) occur as specified in coding sheet.
Obtain from adolescent intake form, police report, and pre-disposition report.
If information is not indicated, Code 9 (NA).

87. Party Who Reported Offence(s)

The person(s) who reported the offence to the authorities.
Obtain from police report, predisposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

Victim(s) Variables

88. Number of Victims

The number of victims the adolescent sexually abused.
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 99 (NA).

89. Age of Victim or Age Range of Victims

The age of the victim(s) the adolescent sexually abused.
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 99 (NA).

90. Gender

The gender of the victim(s).
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

92. Relationship to Offender

The victim's relationship to the adolescent (i.e. sibling, baby-sitting client, etc.).
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

Circumstances After the Sexual Offence(s)

92. Remorse/Empathy for Victim(s)

Did the adolescent feel remorseful for sexually abusing the victim(s).
Obtain from police report, pre-disposition report, and adolescent intake form.
If information is not indicated, Code 9 (NA).

93. Victim(s) Received Therapy/Medical Care

Does the adolescent know if the victim(s) received any form of therapy, or medical care?
Obtain from adolescent intake form, and pre-disposition report.
If information is not indicated, Code 9 (NA).

94. Recidivism

Was the adolescent convicted of further offences following release from the treatment programme?
Obtain from British Columbia Provincial Criminal Record checks.
If information is not indicated, Code 9 (NA).

95. Type of Recidivism

Categorizes the type of offence the adolescent was convicted of following release from his programme.
Obtain from British Columbia Provincial Record checks.
If information is not indicated, Code 99 (NA).

Appendix C

Classification and Definition of
Canadian Criminal Code Sections

CCC s. 151 - Sexual interference of a person under the age of fourteen.

CCC s. 152 - Invitation to sexual touching of a person under the age of fourteen.

CCC s. 153 - Sexual Exploitation.

CCC s. 154 - Seduction of female passengers on vessels, repealed in 1985.

CCC s. 155 - Incest, sexual intercourse with a blood relation.

CCC s. 159 - Anal intercourse.

CCC s. 160 - Bestiality.

CCC s. 163 - Corrupting Morals.

CCC s. 173 - Indecent Acts, exposure.

CCC s. 246 - Overcoming resistance to commission of offence.

CCC s. 264.1 - Uttering Threats.

CCC s. 266 - Assault.

CCC s. 271 - Sexual assault.

CCC s. 272 - Sexual assault with a weapon, threats to a third party or causing bodily harm.

CCC s. 273 - Aggravated sexual assault.

CCC s.334 - Punishment for theft.

CCC s. 335 - Taking motor vehicle or vessel without consent.

CCC s. 346 - Extortion.

CCC s. 348 - Breaking and Entering with intent, committing offence of breaking out.

CCC s. 430 - Mischief.

Motor Vehicle Transportation Act s. 23 - Driver's license.

Young Offenders Act s. 26 - Failure to comply with disposition.