Youth Who Sexually Offend:
Comparing Treatment Populations in British Columbia

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ABSTRACT

This exploratory study compares the demographics, victim characteristics, and offenses of adolescent sexual offenders in Northern British Columbia to those of adolescent sexual offenders in the literature. Specifically, the case files of 95 male clients referred to the Northern Clinic of Youth Forensic Psychiatric Services (YFPS) between 2002 and 2005 for sexual offender assessment or treatment were systematically reviewed. The figures from this study were then compared to those in the literature, including those of a similar study conducted at the Burnaby YPFS clinic, with the use of chi-square analyses, descriptive statistics, and analyses of variance. Similarities and differences between the adolescent sexual offenders in this study, the Burnaby study, and those in the literature are discussed, with a focus on within-group ethnic comparisons. The results support the development of a specialized treatment model and culturally-sensitive service delivery plan for adolescent sexual offenders in the northern region of British Columbia.
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CHAPTER ONE

Introduction

Background

In Canada, adolescents commit sexual assault at a rate double that of adults (Statistics Canada, 2003b). The demand for intervention services for these youths continues although provincial fiscal restraint has forced a reduction of community support services. As a result, agencies working with these youths must conduct critical evaluations of their programs to assess for program efficacy and cost-effectiveness. However, the needs of the individual clients complicate this task.

In British Columbia, the provincial government provides mental health services to youths involved with the criminal justice system through Youth Forensic Psychiatric Services (YFPS), a branch of the Ministry of Children and Family Development. The services provided by this provincial agency are mandated under the authority of the Youth Criminal Justice Act (2002, c.1), the Criminal Code of Canada (R.S., 1985, c.C-46), and under provincial legislation, including the Mental Health Act of British Columbia (R.S.B.C., 1996).

YFPS provides intervention to those youths from the ages of 12 to 18 under order to attend through provisions in the Youth Criminal Justice Act. With a network of clinics and contractors available throughout British Columbia, YFPS receives referrals from Youth Justice Court, Youth Probation Officers, or Youth Custody Centres for assessment, individual counselling, or an offense-specific treatment program funded by the

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1 For the purposes of this paper, the terms adolescent and youth are used in reference to persons from the age of 12 to 18 years.
government. In keeping with government and professional accreditation expectations, as per the Council on Accreditation (COA), YFPS is refining its standards and policies to ensure efficient service delivery from both cost and treatment efficacy perspectives (J. Hayes, personal communications, May, 2005; B. Menzies, personal communications, December 1, 2003; O’Shaugnessy, 2002).

A comparison of the sex offender programs provided by YFPS’ clinics reveals geographical differences in service delivery. In individual clinics throughout British Columbia, clinicians have informally adapted group program materials and content in different ways to meet the perceived needs of their clients (Faigan, 2002). As in other clinics, YFPS clinicians in northern British Columbia have modified group-treatment material in response to their observation that a majority of the youth referred to the program have significant cognitive impairments or learning disabilities (B. Burrows, personal communications, 2003; L. Swanson, personal communications, 2004). As a result, some of the YFPS Sexual Offense Treatment Programs in the province offer an alternative treatment group to provide their clients a better chance for successful program completion.

Regional differences in the treatment programs not only create a difficulty for the agency in assessing the efficacy of specific program components and in developing an accurate description of their client base for program planning, but they complicate the task of developing program standards for a provincial service. While provincial standardization to ensure all clients have equal access to equal service is a justifiable objective, clinicians raise the concern that the standardization of service delivery could result in the creation of expectations that are unrealistic, impractical, or even unethical (Bartel, 2002).
Loss of services due to financial cutbacks, coupled with the push for provincial standardization for treatment and service delivery, raises the concern that programs and policies developed primarily in resource-rich metropolitan areas could result in the expected level of service being unrealistic for British Columbia’s northern service providers to attain. Clinicians experienced in service delivery barriers in northern British Columbia believe standards must be flexible to take into account individual client characteristics, their treatment needs, and the community’s service delivery options [D. Johnson, personal communications, Spring 2004; A. Ostash, personal communications, Spring 2003].

Purpose

Clinicians providing treatment for sexually offending youths referred to YFPS’ northern clinic adapted their program in the belief that their clients possessed similar characteristics to adolescent sexual offenders depicted in the literature, but also possessed a unique combination of cognitive profile, treatment issues, and service delivery obstacles not yet addressed in the literature. The purpose of this exploratory study was to determine if sufficient differences exist between the clients in Northern British Columbia and those in the literature to justify a specialized treatment and service delivery model.

Rationale

In order for province-wide standards for effective treatment of this population to reflect accurately the realities of northern practice, a clear description of the population that the programming is intended to serve is needed: a description not currently available in the literature. Further, attempting to compare the efficacy of one modified program to another
is ineffectual without first ascertaining if the clients participating in the programs have similar characteristics. By comparing findings from a study of youths treated in the metropolitan YFPS clinic located in Burnaby, BC, (Regan, Spidel, Gretton, Douglas, Kumka, & Mitchell, in press) to those treated in northern British Columbia, this study is a step towards effective, empirically based programming for sexually offending youth in northern British Columbia.
CHAPTER TWO

Literature Review

Introduction

Outline

Biases and limitations are inherent in any research, and are often introduced in the work done prior to the research, including the literature review. For this reason, I include a description of the literature review process in the first section of the literature review, Search Strategy, in order that biases and limitations of the review can be clearly identified and taken into consideration, as recommended by researchers (Badger, Nursten, Williams & Woodward, 2000; Bengston & McDermid, 2003; Slavin, 1995). In the section subtitled Use of Labels I address the variety of terms used to refer to adolescents who commit sexual offenses. In the next section, Defining the Problem, I outline the difficulty in determining the frequency of sexual offenses, the cost of sexual offending behaviour, and the importance of early intervention.

During the literature review, I determined that research on this topic falls primarily into four non-exclusive topic areas: identification, assessment, treatment, and recidivism. In section three, Characteristics of Youth Who Sexually Offend, I describe some common misconceptions about adolescent sexual offenders, then, with information from the literature, I provide a description of members of this population, including individual characteristics and typologies based on those characteristics. In Assessment of Youths Who Sexually Offend, the fourth section, I provide the purposes of assessment, address the difficulties involved in the assessment of those with cognitive disabilities, and identify the assessment tools used. The fifth section, Treatment for Youths Who Sexually Offend, covers
the development of treatment programs and goals, and addresses, specifically, the treatment of those with cognitive disabilities.

I discuss research on the effectiveness of intervention and the factors contributing to recidivism in section six, *Post-Treatment Evaluations*, and provide information for clinicians treating this population in section seven, *Clinician Considerations*, followed by the *Literature Review Summary* in section seven.

**Search Strategy**

In order to conduct the literature review for this thesis, I began with what Badger et al. (2000) identify as a "trawl of the literature" (p. 225). I conducted general searches through the electronic and physical resources of both the Geoffrey W. Weller Library of the University of Northern British Columbia, and the Health and Human Services Library of British Columbia (See Appendix 1 for a list of the included databases and keyword search criteria).

The search was restricted to items published in the English language. Publications that were not peer-reviewed were not excluded, but were reviewed as related information and reference sources. The initial searches used combinations of the keywords, as described in Appendix 1, in addition to, and in combination with, those variables identified in the study conducted by Regan et al. (in press). I also used terms from the articles found in combination with the aforementioned keywords, to expand the scope.

The majority of items selected for this review were available physically, electronically, or via inter-library loan through the Health and Human Services Library of the Government of British Columbia, the Geoffrey R. Weller Library of the University of
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Northern British Columbia, the Youth Forensic Psychiatric Services’ library, my personal library, or those of my co-workers. Despite the extensive searches conducted during the selection process, it must be noted that this review remains subject to language, publication, and accessibility biases.

Use of Labels

Righthand and Welch (2001) suggest using the label the youth who has been sexually abusive rather than the more commonly used label of sex offender because the former recognizes the youth as a person and holds the youth accountable for his actions, while the latter term suggests that the youth is, and may always be, an offender. In the literature, researchers have used numerous terms in reference to persons who have committed a sexual offense: sex/sexual offender, child molester, sexual deviant, sexual predator, rapist and pedophile, to name a few.

In agreement with Righthand and Welsh (2001), in practice I prefer to identify the person, rather than the behaviour; it is more accurate and respectful. However, for the purpose of this document, in considering the frequency of reference, the verbose appellation of the youth who has been sexually abusive would quickly become tedious for both the reader and this writer. It is for that reason that at times I use the shorter denotations of sex/sexual offender, with no intent to imply that the behaviour of a youth who sexually offended is not subject to change with appropriate interventions. In addition, although some literature refers to female sexual offenders, or to a male with a single offense, the majority of research subjects are male with more than one offense, and many with more than one victim. For this reason, I use the masculine form throughout this
document in reference to the subject population, and use the plural form in reference to their offenses and victims.

Defining the Problems

Ascertaining the Frequency of Sexual Offenses

The Public Safety and Emergency Preparedness Portfolio Corrections Statistics Committee (2004) issued a report that confirmed the suspicions of many professionals in northern British Columbia: crime rates in Canada are higher in the west, and highest in the north. Of the 441 persons receiving dangerous offender designation in Canada since 1978, 110 were from British Columbia, and 23% of those currently designated as Dangerous Offenders reside in British Columbia, many of them sexual offenders. Yet the sense of urgency to intervene effectively with sexual offenders is a relatively new development, as evidenced by the increased number of studies on this population in recent years.

In the 1940s, medical professionals worldwide would often attend to children with evidence of abuse or sexually transmitted diseases, but an Australian study found that a thorough investigation would seldom follow (Grant, 2000). In the United States, society began to address seriously the maltreatment of children, and in the 1970s, research on sexual abuse began to increase (Ryan, 1999). In Canada, the magnitude of the problem of child sexual abuse was not brought strongly to the forefront until the release of the 1984 Report of the Committee on Sexual Offenses against Children and Youth (Badgely, 1984). Since then, training for mental health clinicians, teachers, social workers, and doctors has emphasized the identification of sexual abuse. These professionals learn to encourage abuse victims to seek justice and support, as an estimated 30% to 80% of child sexual
Youth who sexually offend abuse victims do not purposefully disclose until adulthood (Alaggia & Kirshenbaum, 2005; Brown & Kolko, 1998).

In order to ascertain the number of sexual offenses occurring in Canada, offense data is regularly collected by agencies such as Statistics Canada (2003a), the Research and Statistics Division of the Department of Justice (Latimer, Dowden, Morton-Bourgon, Edgar, & Bania, 2003), the Correctional Service of Canada (1989; 2003), and the British Columbia Police Services Division (2005). The most recent report of 2003 indicates that police in British Columbia recorded the lowest annual number of sexual crimes reported during the past 15 years (British Columbia Police Services Division, 2005). Despite the reassuring appearance of that statistic, professionals working with those charged for sexual offending recognize that reported numbers do not reflect the actual number of offenses committed. For example, through their responses to a 1999 survey conducted by Statistics Canada, Canadians revealed they had experienced approximately 8.3 million incidents thought to be criminal, yet in 2000, police reported receiving reports of 2.5 million incidents (Office of the Auditor General of Canada, 2002).

Some researchers speculate that the discrepancy between offenses committed and offenses reported is due to reasons such as public perception that the courts are unwilling to rely on the testimony of children, families not pursuing the matter to prevent further upset of the victim, or cases not being reported as a result of pressure from other family members (Blackburn, 1993; Christodoulides, Richardson, Graham, Kennedy, & Kelly, 2005; Freeman-Longo, 1990; Woods, 1997). This large discrepancy between offenses committed and offenses reported is troubling, especially when considering the impact of unreported sexual offenses.
As with sexual offense rates, determining the number of child victims of sexual abuse is also a difficult task. The recent literature from Canada tells us that 29% of the victims of violent offenses, which includes sexual offenses, were youths, and 13.1% of those were under 14 years of age (Public Safety and Emergency Preparedness Portfolio Corrections Statistics Committee, 2004). A British Columbia publication (Gingell, 1993) showed 24% of sexual abuse victims were under the age of five, 52% were between six and 12, and 24% were 13 to 18 years old. Again, these numbers only reflect reported cases of processed offenses; the number of unreported offenses is estimated to be much higher.

Freeman-Longo and Wall (1986) wrote an article providing general information to the public on sexual offender treatment, and stated that identification of a single offender does not indicate identification of a single victim. They stated that in one study, 53 offenders confessed to committing 25,757 offenses. Bernet and Dulcan (1999) found that 90% of sexual abuse victims are 3-16 years old; the majority are under the age of 9, and 25-40% are younger than 6 years old.

During the past decade, the increasing amount of information about the frequency of child sexual abuse has brought with it new interest in the effects of abuse based on victim gender. Traditionally, sexual abuse studies have focused primarily on female victims, presumably because the majority of persons charged with sexual offending are male. With over 300 books and articles published during the last 30 years specifically about male victims of sexual abuse (Mathews, 1996), it is now becoming common knowledge that male children are frequent victims of sexual abuse, often at rates comparable to that of females (Becker, Hunter, Stein & Kaplan, 1989; Tremblay & Turcott, 2005).
Of all female victims of sexual offenses in Canada in 2003, 22.3% were under the age of 12; they were the victims in 8.3% of aggravated sexual assaults, in 2.7% of sexual assaults with a weapon, and in 43% of all other sexual offenses (Statistics Canada, 2003a). Meanwhile, over 50% of the male victims in Canada that year were under the age of 12; they were the victims in 66.7% of all aggravated sexual assaults, in 17.2% of sexual assaults with a weapon, and in 51% of all other sexual offenses (Statistics Canada, 2003a).

*Ineffectual reports.* Although research has shown that many victims do not report their sexual victimization to the authorities, others do report but their complaints do not reach the courtroom (Christodoulides et al., 2005; Worling & Curwen, 2000). Affirming these claims, the last summary report of crime statistics issued by Statistics Canada (2003a) shows some disturbing figures in relation to how some sexual offense complaints are processed; in 2003, 6.9% of sexual assaults and 5.6% of other sexual offenses reported to the police were not processed through the justice system because complainants declined to press charges. In Canada, it is Crown Counsel that approves charges on an accused, not the victim; however, police are required to submit a report to Crown Counsel advising them of the details of the offense and recommending appropriate charges, as supported by the collected evidence. Crown Counsel’s decision not to proceed with the case takes into account a victim that is not willing to provide a statement or testify in court, especially where the victim’s input is critical for burden of proof due to lack of other evidence.

Victims of abuse have cited not wanting to report, or cooperate for prosecution of the offender, for many reasons. Some fear that the offender would act on threats of violence against the victim or a loved one. Some fear of being blamed. Other reasons for not supporting the complaint through the judicial process include: fear of punishment by
parents for cooperating in any way during the offense; being led to believe the actions were not wrong, especially if the victim experienced any sexual arousal or enjoyment; adhering to a promise in belief the offender would adhere to his promise not to do the same to a sibling; fear of testifying in court and having everyone present hear of their pain and embarrassment; and fear the offender would be taken away, a consequence that would be more painful to other members of the family than suffering through the abuse itself (Clients, personal communications, 1990-2006).

Even more distressing than police and Crown Counsel being unable to pursue justice due to victims feeling unsafe are the statistics on sexual offenses that victims reported to police, but the police did not forward that information to Crown Counsel in support of charges. Across Canada in 2003, “departmental discretion”\(^2\) (Statistics Canada, 2003a., p. 71) prevented 5.1% of sexual assault complaints, and 5.4% or other sexual offense complaints from reaching court, while 6.3% of sexual assault complaints and 11.2% of other sexual offense complaints that year did not proceed for a reason coded as “Other”\(^3\) (Statistics Canada, 2003a., p. 71). To understand these omissions, Soulliere (2005) conducted a study in Windsor, Ontario, of police decisions in sexual offense cases, including how police differentiated between those cases they coded as “departmental discretion” and those they coded as “other”. Soulliere explained that many of the cases falling under the “other” category were those files marked as being unfounded: the complaints were determined to be false early in the police investigation. Consequently, no

\(^2\) Departmental discretion indicates complaints in which police did not proceed with further investigation of the complaint or did not proceed with charges against the suspect (Soulliere, 2005, p.426).

\(^3\) “Other types of ‘cleared otherwise’ include suicide and death of the accused or complainant, reasons beyond the control of the department (e.g., policy), accused is less than 12 years of age, committal of accused to a mental facility, accused is in a foreign country, diplomatic immunity or the accused has already been sentenced” (Statistics Canada, 2003a, p.71).
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further investigation took place and the matter was not reported to Crown Counsel in support of charges.

The grounds for some complaints being disposed of under the heading “departmental discretion”, however, are not as easily dismissed. Soulliere (2005) stated:

Open coding of the ‘unfounded’ and ‘departmental discretion’ complaints revealed the following justifications: contradictory evidence, insufficient evidence, inconsistencies/discrepancies in victim’s account, history of false complaints, victim intoxicated, victim undergoing psychiatric care, victim is a prostitute, victim is a runaway, age of victim, victim has mental/physical handicap, interaction between victim and suspect after the assault is not typical, mitigating circumstances regarding the suspect, reporting not prompt, victim is not a competent witness, victim’s emotional reaction is not typical, and victim is uncooperative with police (Soulliere, 2005, p. 426).

Although some of the above justifications are of concern, most of the reasons cited for not proceeding with sexual offense complaints are genuinely alarming. Given the number of complaints presumably cleared in this manner across Canada (Statistics Canada, 2003a), it is evident that sexual offenses are not only under-reported, but those that are reported are not as seriously pursued as should be expected.

Plea bargaining. Even when a sexual offense complaint is actioned, that is, processed by the police with charges laid and approved by crown in preparation for a court appearance, another issue occasionally arises that interferes with attempts to correctly ascertain the number of sexual offenses: plea bargaining. Piccinato (2004) explains that plea bargaining is defined as making an agreement with the accused, where the accused agrees to plead guilty in exchange for some benefit, such as pleading guilty to a related charge with a less punitive consequence. Plea bargaining may take place under a variety of circumstances, but is often used to reduce time and costs by eliminating lengthy court
trials. In respect to sexual offending counts, the most consequential plea bargain occurs when the accused agrees to plead guilty in exchange for a lesser charge:

[An] example may involve an accused who is charged with a number of offenses, such as sexual assault, forcible confinement and sexual exploitation, that arise out of one incident, pleading guilty to the one "all-inclusive" count of sexual assault. In this case, the prosecutor may withdraw the counts of forcible confinement and sexual exploitation, if the accused admits to those acts through the plea of guilty to the one count of sexual assault (Piccinato, 2004, pp. 15-16).

As in the example, this practice can falsify counts of the number of sexual offenses that went before the court in Canada by identifying one sexual assault charge rather than one sexual assault plus two other sexual offenses. Even more detrimental are those plea bargains where a sexual offender pleads guilty, not to sexual assault, but to a common assault. This bargain can be the best chance to get a conviction when the victim’s testimony is hard to obtain (nonverbal, child, or unwilling to testify). However, in this example, the courts would count this case with other, nonsexual, offenses, further distorting the true number of sexual offenses represented by court statistics. In addition, the accused would not be convicted of a sexual offense, so would, therefore, not be ordered by the court to attend, participate, and successfully complete a sex offense-specific treatment program.

Thus, the impact of under-reporting is considerable. Each unreported case potentially represents an unsupported victim, an untreated and unsupervised offender, and an increased likelihood of more victims. Furthermore, unreported cases create inaccurate statistics upon which government and community agencies base their decisions for community protection, program funding, and service development. The accurate reporting and processing of each sexual offense is the crucial first step towards the identification and
treatment of those who offend sexually, and is a critical step for the prevention of future sexual abuse victims.

**Costs to Society**

In the literature on sexual offenders, researchers usually make a point of acknowledging the victim of sexual abuse, typically in justification of the importance of treating this population (Brown & Kolko, 1998; Bullens & Van Wijk, 2004; Ellerby & MacPherson, 2002; Gingell, 1993). They often direct these references to the person or persons chosen by the offender to be a victim: the one against whom the actual offenses were committed. However, I believe it is important to recognize that there are multiple victims for each incident of sexual abuse, including: those who were directly offended against, family and friends of the victim, family and friends of the offender, future partners and family members of both parties, future offspring of both parties, and their individual communities.

**Costs to the victims.** Browne and Finkelhor (1986) reviewed research on the impact of child sexual abuse, and identified numerous negative effects: guilt, shame, hostility, severe fears, anxiety, distress, depression, sleep disturbances, changes in eating habits, excessive sexuality, exposure of genitals, open masturbation, difficulties at school, running away, delinquency, and thoughts of suicide. Browne and Finkelhor acknowledged that many of the studies reviewed lacked standardized outcome measures and adequate comparison groups, so they were not able to determine if their findings were indicative of all child sexual abuse victims.
Widom (1996) studied 908 children who had been sexually abused prior to age 11. They matched subjects to a control group, and followed their progression into young adulthood to determine if a history of sexual abuse would result in higher rates of delinquency through adolescence. Of those with an abuse history, 27% were arrested, compared to 17% in the control group. Contrary to expectation, children who had been physically abused were more likely to be arrested for sexual offenses than those who had been sexually abused. Widom suggested that sexual abuse might strongly influence the victim and affect their functioning in various ways; however, Widom did not provide any of the data collected nor adequately explain how the conclusions were reached.

Finkelhor (1990) pointed out that research on children who recently disclosed having been sexually abused showed that boys experienced many of the same symptoms as girls. Tremblay and Turcotte (2005) described the effects of sexual abuse on males by outlining how being victimized, particularly by an older male, results in gender-role confusion and often raises questions for the victim about his own sexual preference. Referring to the many ways in which the therapeutic process is at odds with the demands of masculinity as described in the literature, they explain that the male sexual abuse survivor, originally placed in a submissive situation during the abuse, may feel he is in another submissive situation in asking for, and receiving, the necessary help (Tremblay & Turcotte, 2005).

Presenting a different perspective, Rind, Tromovitch and Bauserman (1998) released a highly controversial study claiming that the effects of child sexual abuse are not as negative as many believe, and that when a child is not coerced or damaged by the interaction, it should be called adult-child sex, rather than child abuse. In addition to
political condemnation of the study and public outcry over Rind et al.’s assumption that a child can consent to sexual relations with an adult, numerous responses to the article were issued by fellow researchers, including Dallam, Gleaves, Cepeda-Benito, Silberg, Kraemer, & Spiegel (2001), Lilienfeld (1998), and Spiegel (2000), denouncing the methodology and conclusions of the study. Since that time, researchers have continued to debate the ability to empirically prove specific negative effects are caused by child sexual abuse, and while it is unlikely that an accord will ever be reached on the Rind et al. matter, there is little doubt that for many, the effects of child sexual abuse can be negative and long lasting (National Clearinghouse on Family Violence, 1997a). However, because of the research conducted to date, we do know that, for those that have been direct or indirect victims of sexual abuse, the emotional cost can be immeasurable (Feiring, & Taska, 2005; Kallstrom-Fuqua, Weston, & Marshall, 2004; Wilken, 2003: Woods, 1997).

Cost to the taxpayers. In order to determine the expense of offending behaviour, but not intending to minimize the emotional cost to the victims, researchers have quantified reported crimes with their related expenses, and the financial costs are staggering. The government of Canada estimated the cost of all crimes to be $46 billion a year (Office of the Auditor General of Canada, 2002), and the government of British Columbia budgets over $39 million a year exclusively for court costs (Elian, 2005). Money from both budgets had to cover the costs of processing the 17,548 sexual offenses heard in Canadian courts in 2003 (Correctional Service of Canada, 2003). British Columbia police received 3,719 sexual offense reports in 2004 (British Columbia Police Services Division, 2005) and that same report revealed that the Royal Canadian Mounted Police processed 111 sexual offenses in a single northern British Columbia community that year. Even with the
knowledge that these figures under-represent the actual number of offenses committed, they constitute a significant amount of victim suffering, police expense, and court costs for the communities affected, with all of those costs borne by the taxpayers.

For the taxpayers, the financial burden resulting from those who sexually offend does not end at court. Of those persons convicted for a sexual offense, many receive a sentence that includes incarceration (Statistics Canada, 2003c). Between 1978 and 1988, custody admissions for sexual offenses increased from 6.5% to 12.9% (Correctional Service of Canada, 1989). Kahn and Chambers (1991) compared the cost of outpatient therapy in 1988 to custody, and calculated that the cost of outpatient therapy for one year for 10 clients was $27,000 while 10 clients in residential or custody programs for one year was $393,000. Thomas (2005) conducted a review of statistics collected for Statistics Canada, and produced a summary of findings on youth court activities in Canada from 2003 to 2004. The study revealed that 7.1% of convictions of youths for crimes against the person that year were for sexual offending behaviour. Of those convicted, the mean custody term ordered was 195 days for sexual assault, and 152 days for other sexual offenses. Probation was ordered for 87% of those youth convicted, with an average sentence including 529 days (Thomas, 2005). In Canada, the number of adult males incarcerated federally for sexual assault rose from 13,037 in 2001 to 16,214 in 2003 (Public Safety and Emergency Preparedness Portfolio Corrections Statistics Committee, 2004). With the cost over $80,000 per year, or $220 per day, for each incarcerated individual (Correctional Service of Canada, 2003), the financial burden on the taxpayers is arduous.

Cost of not intervening. Although the cost of processing a sexual offense through the justice system is expensive, there are also significant consequences for not intervening.
In explaining the importance of early intervention for sexually offending youths, Gingell (1993) noted that almost two-thirds of adult sexual offenders in Canadian federal prisons committed their first sexual offense in adolescence. However, reluctance to report sexual offenses to the authorities is not an exclusive characteristic of victims: many parents who are aware of their child's sexually intrusive behaviors are hesitant to report the behavior to the authorities for fear of criminalizing the youth or for fear of embarrassment in the community. Instead, some of these parents will attempt to address the problem behavior through a community counselor (Gingell, 1993). Families that are financially well off, and reside in an urban area, may be able to access private, qualified treatment for their sexually intrusive child by hiring a therapist specializing in the treatment of sexually intrusive behavior. For less fortunate families or for those residing in rural northern communities, the ability to access a private professional specializing in the treatment of sexual offending behavior is almost nonexistent (National Clearinghouse on Family Violence, 2002).

Although treatment can be costly for the taxpayers (government-subsidized treatment) or the protective parent (private counseling), the price for not treating sexually intrusive behaviors is high in comparison. The financial expense, exclusively, of not intervening with a high risk youth was calculated to be between $1.7 and $2.4 million over the youth’s lifetime (Cohen, 1998). As researchers of adults who sexually offended pointed out, many adults began offending during adolescence (Brown & Kolko, 1998; Groth, Longo, & McFadden, 1982; Truscott, 1993), therefore, early treatment for sexually intrusive behaviors is cost effective from the perspectives of both the criminal justice system and that of the reduced victim population. When taken into account with the
emotional costs paid by each victim, the price for not providing early intervention may be significantly higher.

*Characteristics of Youths Who Sexually Offend*

*Myths Dispelled*

Despite increased media coverage of youth crime rates, it is difficult for some people to believe that youths commit sexual offenses (parents of offenders and victims, personal communications). As a result, many misconceptions exist about adolescent sexual offenders. As previously mentioned, many adult sexual offenders have admitted to the commission of sexual offenses during their adolescence (Brown & Kolko, 1998; Truscott, 1993). Ryan, Miyoshi, Metzner, Krugman and Fryer (1996), reported that the majority of sex offenders commit their first offense before the age of 15. In their study, 26% had displayed sexually abusive behaviour before the age of 12 and 63% had previously committed non-sexual crimes (Ryan et al., 1996). Langstrom (2001) acknowledges that sexual offenses by younger children do occur, but the information is difficult to access in his country because the age of legal responsibility in Sweden is 15 years. Similarly, the age of legal responsibility is 12 years in Canada, so very young offenders are not charged or required to attend treatment. However, Canadian police have documented those reports of sexual offense where the accused was under the age of 12, and Statistics Canada (2003a) informs us that 2% of sexual assaults and 2.5% of other sexual offenses were committed by someone under the age of 12. Again, this represents reported offenses; the number of actual offenses committed by children under the age of 12 is unknown.
Another misconception about adolescent sexual offenders is that if they do commit an offense, it is rare. On the contrary, researchers estimate that adolescents account for more than a third of all sexual assaults (Brayton, 1996; Langstrom, 2001; National Clearinghouse on Family Violence, 1997b). In a United States study, Ryan et al., (1996) estimated that more than 50% of the sexual abuse of boys and up to 25% of the sexual abuses of girls are committed by youths, with the average young offender being 14 years old. Valliant & Bergeron (1997) report that adolescents perpetrate 30-50% of child sexual abuse cases, and Bourke and Donahue (1996) say adolescents commit 60% of all sexual offenses against children under the age of 12. There is some discrepancy between the estimates. Nevertheless, the evidence indicates that sexual offending by youths is not an infrequent occurrence.

Another myth is that adolescents do not commit sexual offenses; they are merely trying to learn about sex. Langstrom (2001) points to findings that contradict that theory; the findings show that many young sex offenders had sexual relations with an age-appropriate and consenting partner prior to committing their first sexual offense. Others believe that adolescent sexual offenders commit their offenses because someone had once sexually offended against them. Although many sexual offenders have disclosed being victims of sexual abuse as children (Falls, 2001; Freeman-Longo, 1990; Johnson, 1997; Kahn & Chambers, 1991; National Crime Prevention Council of Canada, 1995), Gal and Hoge (1999) point out that the frequency of sexual abuse in the history of youths who sexually offended is not disproportionate to the frequency seen in youths in the general population. Further, not every person who was sexually abused as a child becomes a sexual offender themselves (Freeman-Longo, 1990).
One of the most naïve misconceptions is that adolescent sexual offenders do not commit serious sexual offenses and were probably arrested for an innocent, inappropriate touch that occurred while playing. In reality, the offenses committed by many adolescent sexual offenders are far from innocent. Fehrenbach, Smith, Monastersky and Deisher (1986) found the most frequently occurring offense was sexual touching without consent (59%), the second most frequently occurring offense was rape (23%). This was followed by exposure (11%) and other no-contact offenses such as voyeurism and obscene phone calls (7%). The majority of direct victims of the subjects in their study were under the age of 12 (over 60%). Smith, Monastersky and Deisher (1987) repeated much of the study the following year and of those youth, 77.5% had attempted or succeeded in penetrating their victim during the assault.

Demographics

Gal and Hoge (1999) stressed the importance of identifying the characteristics of youths who commit sexual offenses to determine effective interventions that will address the specific needs of the individual. In an attempt to gain a better understanding of youth who sexually offend and to identify effective interventions, researchers originally reviewed studies about adult sexual offenders, and then showed a renewed interest in conducting studies specifically on adolescent sexual offenders shortly thereafter (Abel & Rouleau, 1990; Abel, Mittelman & Becker, 1985; Becker & Kaplan, 1993).

Gender and race. One of the first detailed reviews on adolescent sexual offenders was released in 1987 when Davis and Leitenberg examined offense and victim characteristics, offender characteristics, and treatment and recidivism, and concluded that
Youth who sexually offend

the research had numerous large gaps, but some consistent findings. Specifically, the literature review by Davis & Leitenberg (1987) reasserted that adolescents are responsible for a large share of sexual offenses committed, and noted a high rate of male victims. They stated that victims of non-contact sexual offenses were typically female, whereas more of the sexual assault victims were male, and there was overrepresentation of one gender in the offender population: male (Davis & Leitenberg, 1987). The Correctional Service of Canada (2003) reported that of all persons charged with a sexual offense in 2003, 98% were male (84% were adult males, and 14% were male youths). These proportions have remained about the same over the last ten years (British Columbia Police Services Division, 2005).

Another overrepresentation in the offender research is that of First Nations people (Allan, Allan & Kraszlan, 2001; Johnson, 1997; Moore, 2003).

In his profile of the First Nations representation in federal corrections, Moore (2003) explained that the 1996 Statistics Canada census was reworded to better identify First Nations heritage representation. Instead of asking if a person had aboriginal ancestry, as was the question of the 1991 census, the revised question asked if the respondent was of Aboriginal descent; specifically, First Nations, Metis, or Inuit. The results of that census revealed that First Nations people represented 8% of the population of Canada, with 17% residing in British Columbia, the majority in the northern areas. Moore’s profile went on to disclose the fact that although First Nations people represented only 8% of the country’s population, they represented 15% of federally incarcerated offenders across Canada. First Nations people were incarcerated for sexual offenses at a rate 6% higher than non-First Nations people were, and they represented over 60% of inmates in custody in the Prairie Provinces. These findings supported those of Johnson (1997). Johnson’s study of offenders...
of First Nations ancestry in Canada revealed that over 36% of First Nations men in federal custody were serving prison sentences for sexual offenses. However, the overrepresentation of offenders of First Nations ancestry in prison is not unique to Canada; aboriginal people are overrepresented in the prison systems of other countries as well, such as Australia (Allan, Allan, & Kraszlan, 2001). Clearly, these statistics indicate a need for researchers to examine the reasons for this overrepresentation to aid in the development of effective and culturally sensitive intervention methods.

**Age.** A meta analysis that included close to 75,000 youths arrested for general criminal activity (Latimer, et al., 2003), found the mean age of the subjects to be 15.23 years. The mean ages of research subjects in some studies referenced for this literature review are similar to that found in Latimer et al., as shown in Table 1. It is important to recall, however, that despite the mean age of the research subjects, many sexual offenders began their offending behaviour years prior to their first conviction (Falls, 2001; Ryan et al., 1996; Statistics Canada, 2003a). What appears to be evident from this comparison is that youths are close to 15 years of age when they become the focus of research on adolescents that commit criminal offenses.

**Family Background and Attachment**

Research into differences in empathy between adolescent sexual offenders and non-sexual offenders showed that those that offended sexually scored significantly lower in empathy (Burke, 2001). One of the factors speculated to contribute to the development of poor empathy and sexually intrusive behaviour is the family, particularly exposure to violence in the family or the experience of physical or sexual abuse as a child (Fehrenbach...
### Table 1

**Mean Ages of Adolescent Sex Offenders**

<table>
<thead>
<tr>
<th>Sample size</th>
<th>Mean age</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sexual offense studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Becker, Cunningham-Rathner, &amp; Kaplan (1986)</td>
<td>67</td>
<td>15.47</td>
</tr>
<tr>
<td>Fehrenbach, Smith, Monastersky &amp; Deisher (1986)</td>
<td>305</td>
<td>14.80</td>
</tr>
<tr>
<td>Smith, Monastersky and Deisher (1987)</td>
<td>262</td>
<td>15.34</td>
</tr>
<tr>
<td>Becker, Hunter, Stein, &amp; Kaplan (1989)</td>
<td>126</td>
<td>15.50</td>
</tr>
<tr>
<td>Simourd, Hoge, Andrews, &amp; Leschied (1994)</td>
<td>256</td>
<td>15.20</td>
</tr>
<tr>
<td>Hunter &amp; Figueredo (2000)</td>
<td>235</td>
<td>14.70</td>
</tr>
<tr>
<td>Veneziano, Veneziano, &amp; LeGrand (2000)</td>
<td>74</td>
<td>14.00</td>
</tr>
<tr>
<td>Allan, Allan, &amp; Kraszlan (2001)</td>
<td>334</td>
<td>15.70</td>
</tr>
<tr>
<td>Sockett-DiMarco (2001)</td>
<td>59</td>
<td>15.47</td>
</tr>
<tr>
<td>Aylwin, Reddon, &amp; Burke (2005)</td>
<td>87</td>
<td>16.10</td>
</tr>
<tr>
<td>Sexual offenders</td>
<td>Σ=1805</td>
<td>M=15.23</td>
</tr>
</tbody>
</table>

2. Meta analysis of adolescent offenders (all crime types)

<table>
<thead>
<tr>
<th>Sample size</th>
<th>Mean age</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latimer, Dowden, Morton-Bourgon, Edgar &amp; Bania (2003)</td>
<td>75 000</td>
<td>M=15.23</td>
</tr>
</tbody>
</table>

* Not included in reported results

et al., 1986; Widom, 1996). In one of the largest samples of young children with sexual behaviour problems studied, with 37 children ranging in age from three to seven years, Silovsky and Niec (2002) discovered that 38% had a substantiated history of sexual abuse, but 68% had been exposed to interpersonal violence. Similarly, Ford and Linney (1995) found that adult child molesters had experienced significantly more physical and sexual abuse, and more intrafamilial violence in their childhood than had the other types of offenders.
Marshall and Barbaree (1990) identified developmental adversity as an influential factor for the formation of a sexually abusive youth, a concept supported by Hudson and Ward (2000),

...developmental adversity does two things. These negative experiences fail to assist the young male to develop a sense of self-confidence or personal efficacy. Second, they also produce a variety of negative attitudes, emotions, and beliefs toward other people, all of which inhibit the development of the skills needed to deal appropriately with the developmental challenges posed by puberty. Most particularly, these outcomes reduce the chances that the young male will acquire the socially required separation between aggression and sexuality. Moreover, it is likely that he will fail to progressively develop close relationships with peers. It also becomes more likely that he will be socially inept, having difficulties in the crucial areas of intimacy and empathy, as well as exhibiting hostile and aggressive attitudes, particularly toward women” (p. 495)

Hunter (1999) states that a review of the literature shows 20-50% of the youths have histories of physical abuse, while 40-80% have histories of sexual abuse, in contrast to the findings of Widom (1996) and Silovsky and Niec (2002). Hunter went on to say that “the age of onset, number of incidents of abuse, the period of time elapsing between the abuse and its first report, as well as perceptions of familial responses to awareness of the abuse are all relevant in understanding why some sexually abused youths go on to commit sexual assaults while others do not” (Hunter, 1999, p. 3).

In another study (Hunter & Figueredo, 2000) of over 150 youths, more than 75% had been exposed to sexual or physical violence toward females, 90% had been exposed to some form of male-modeled antisocial behaviour, and 75% reported childhood sexual victimization. They also found that adolescents who sexually offended against children had lower levels of self-confidence than non-offending youths. Five years later, Hanson and Morton-Bourgon (2005) conducted a meta-analysis with 29,450 participants to examine
potential recidivism factors. They concluded that the family environment plays a significant role in the development of the offending behaviour:

...models suggest that adverse family environments provide the breeding grounds for sexual offending. Lacking nurturance and guidance, the potential sexual offender develops problems in social functioning (e.g., mistrust, hostility, and insecure attachment) that, in turn, are associated with social rejection, loneliness, negative peer associations and delinquent behavior. The form of sexuality that develops in the context of pervasive intimacy deficits is likely to be impersonal and selfish and may even be adversarial. Further contributing to the risk of sexual offending are beliefs that permit non-consenting sex (p. 1154).

The connection between attachment difficulties and sexual offending behaviour has been frequently examined in the sexual offender population (Marshall, Hudson, & Hodkinson, 1993). Marshall’s 1989 hypothesis (as cited in Marshall, 1993), which states that marked attachment and intimacy deficits characterize adolescent sexual offenders, has been supported repeatedly in the literature with few exceptions. In a study of the families of 109 adolescent offenders, Bischof and Stith (1992) compared families of youth who had sexually offended to those of youth who had offended non-sexually. When asked to describe their families, the sexual offenders described their families as being more cohesive than did the non-sexual offenders, demonstrating either denial or lack of awareness of their family problems (Bischof & Stith, 1992). In a follow-up study, Bischof and Stith (1995) researched 109 subjects in residential and outpatient programs in the Metro Washington, DC area. Bischof and Stith distributed a Family Environment Scale to the participants for completion and 93% of the questionnaires were returned to the researchers. Based on the scale results, Bischof and Stith reported finding no difference between race, parental employment, or occupation between the families of sexual and non-sexual offenders. However, they did not report pre-testing for literacy abilities prior to
distribution of the pencil and paper tests, which were individually completed by the participants. Without confirmation of the individuals' ability to accurately read and comprehend the questionnaire, their findings are inconclusive.

The family descriptions reported by Bischof and Stith (1992) were not consistent with the findings of earlier research by Blaske, Borduin, Henggeler, and Mann (1989) at the University of Missouri. Blaske et al. found that the backgrounds of adolescent sex offenders were characterized by multiple disturbances in their relations with family and peers, and by higher rates of anxiety. In addition, unlike their findings on general adolescent delinquents that showed poor family bonding but strong bonding to socially-deviant peers, Blaske et al. found the adolescent sexual offenders had low family cohesion and low peer bonding. Likewise, Ward, Hudson and Marshall (1996) found that the majority of sexual offenders in their New Zealand study were insecurely attached.

Attempts by the sexual offenders to present their families in a favourable light to researchers may explain the discrepancy between youth perception of a cohesive family and observable characteristics to the contrary, but this writer's experience indicates that this genuine misperception of the family dynamics is common in this population.

Kelley, Lewis, and Sigal (2004) found that a parent with substance abuse issues played a more detrimental role in the youth's success in treatment than a mother with psychiatric illness. They also found that youths with depressed mothers had higher rates of somatic complaints, and those youths with the greatest number of failed placements prior to treatment would have the greatest number of incident reports during their first 8 months in the treatment program. Other attempts to understand why youths offend sexually have
Youth who sexually offend

spurred researchers to take a closer look at the relationship between parents and teens and its predictive ability on the youth's offense pattern.

Chambers, Power, Loucks and Swanson (2001) probed the relationships between parental bonding and the youth's offending style in a study in 122 adolescent offenders in Scotland but found no direct links between parental care and the youth’s offense pattern. In Ireland, a more recent study on the attachment styles of sexual offenders found that 93% had an insecure adult attachment style and those who had offended against children reported an externalized locus of control and significantly more loneliness (Marsa, O’Reilly, Carr, Murphy, O’Sullivan, Cotter, & Hevey, 2004).

One study that did find a link between sexual offending and the relationship with the parent was that of Hummel, Thömke, Oldenburger, and Specht (2000). Hummel et al. looked at a small sample of 16 adolescent sexual offenders to determine if there was a link between offense patterns and offender sexual abuse victimization. They discovered that the youth's relationship to the parent figure was associated with a history of sexual abuse, not as perpetrator, but as victim. The authors speculated that loss of parent and related attachment problems are linked to inadequate social skills and lack of assertiveness, which may make the youth a more desired target for sexual abuse. Prior sexual abuse victimization is another frequently reported characteristic of this population (Falls, 2001; Freeman-Longo, 1990; Johnson, 1997; Kahn & Chambers, 1991; National Crime Prevention Council of Canada, 1995).

In an overview study of the influence of family environment on young reoffenders in the United Kingdom, Hagell and Newburn (1996) focused on the social environment of youths who were repeatedly arrested by the police. In their study, 500 potential
"reoffenders" were identified, but only 74 could be located for follow-up, supporting research, which shows many of these youths are from homes with high levels of disruption and a variety of living circumstances. Hagell and Newburn summarized their findings by identifying the need for intervention services to meet the requirements of the clientele, rather than the clientele trying to meet the mandate of the service providers.

**Social Skills**

A common theme in the reviewed literature on sexually intrusive adolescents is their inadequate social skills. Social skill deficits were second only to gender in the frequency in which they were identified as a common characteristic of adolescent sexual offenders (Fagan & Wexler, 1988; Feherenbach et al, 1986; Hudson, Ward & McCormack, 1999; Maag 2005). Maag (2005) commented that training in social skills training has become a standard intervention for youths with behavioural problems, but these interventions are targeting behaviours which are not socially valid, are not matching training techniques to the causes for the youths’ failure in social skills, and are not showing large changes in peer acceptance.

Maag suggests that replacement behaviour training may be an avenue to increase the effectiveness of social skill training as an intervention. Some studies have shown a significant need for this type of intervention with members of this population who are often characterised as being socially inept; Feherenbach et al. (1986) identified 65% percent of the 305 subjects in their study as being socially isolated from their peers. Thirty-four percent of their subjects reported having a couple of friends, but with whom they were not close, and 32% of the subjects reported they did not have a single friend. Feherenbach et al.
Youth who sexually offend

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also found that youths who had committed rape had the least number of close peer relationships, with 73.9% being unable to identify one close friend. Lakey (1994) identified some similarities and differences between normal adolescent behaviour and that of the adolescent sexual offenders, as shown in Table 2. In a comparison study on the social skills of rapists, child molesters, violent sex offenders, and non-violent offenders, Ford and Linney (1995) found the groups did not differ in their perceived ability to develop relationships with their peers, but “child molesters showed preference for initiating inclusion rather than receiving it, and they reported the greatest desire to control interpersonal situations” (Gal & Hoge, 1999, p. 8).

<table>
<thead>
<tr>
<th>Table 2</th>
</tr>
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<tbody>
<tr>
<td>Comparison of adolescent sexual offenders and non offenders (Lakey, 1994)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Non Offender</th>
<th>Sexual Offender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self absorbed</td>
<td>Obsessively self absorbed</td>
</tr>
<tr>
<td>Shows casual interest in the opposite sex</td>
<td>Opportunistic and manipulative</td>
</tr>
<tr>
<td>Seeks company of same age peers</td>
<td>Poor social skills limit ability to make or maintain relationships</td>
</tr>
<tr>
<td>Will build up to a sexual relationship</td>
<td>Immediate sexual gratification sought</td>
</tr>
<tr>
<td>Rebels in legitimate ways</td>
<td>Rebels by doing the forbidden</td>
</tr>
</tbody>
</table>

In another comparison of sexual offenders to non-sexual offenders, Valliant and Burgeron (1997) compared 16 adolescent male sexual offenders, 13 general offenders, and 13 non-offenders. Using psychometric tests, they found no significant differences in general intelligence between the groups, but noted that youth who sexually offended scored higher than non-offenders on psychopathic deviancy, chemical abuse, and antisocial...
tendencies. The sexual offenders also scored higher on assault and social introversion, but lower on indirect hostility and thought disturbances than did the non-sexual offenders.

Shields (2004) compared background information from sexual offenders and non-offenders and found the sexual offenders had higher incidences of depression, sexual abuse victimization, and poor peer relations.

Another study, done in the Netherlands (Van Wijk, Van Horn, Bullens, Bijleveld, & Doreleijers, 2005), examined 277 subjects and focused on the differences between juvenile rapists and sexual assaulters (n= 57), child molesters (n = 55), non-sexual violent offenders (n = 85) and non-violent offenders (n = 80). Van Wijk et al. determined that differences did exist between the groups: sexual offenders had lower IQ scores than the violent offenders, child molesters scored higher on neuroticism and lower on relationships with peers, and child molesters had the lowest school drop out rate. Similarly, Farr, Brown, and Becket (2004) compared 44 adolescent sexual offenders in the United Kingdom with 57 adolescent non-offenders to examine the attitudes conveyed by these youths in social settings. They found no differences in levels of masculinity, but sub-scale scores on callous sexual attitudes towards females and adversarial attitudes towards females and sexual minorities were statistically significant.

Hudson, Ward and McCormack (1999) saw deficits in social skills to be so influential that they identified it as being a causal factor in adolescent sexual offending. Reiterating that statement the following year, Hudson and Ward (2000) reviewed over 140 articles and concluded that social competency deficiencies are the foundation for the development of sexual aggression. These findings reinforced some of the conclusions of Knight and Prentky (1993) who had stated that most sex offenders: have significantly
lower competence in social skills; are more impulsive; have a greater history of criminal acts; are more likely to have come from dysfunctional, abusive families; and are more likely to have had problems in school. Later studies re-confirmed the earlier literature results on the links between sexual offending and social ineptness in the adolescent sexual offender (Abracen, Mailloux, Serin, Cousineau, Malcolm, & Looman, 2004). Despite the strong correlations between sexual offending behaviour and poor social skills, lack of social skills has not been empirically proven a causal factor.

**Academic Performance**

With the exception of the small sample study of Valiant and Burgeron (1997), the literature has shown that a majority of adolescent sex offenders have learning difficulties or demonstrate behavioural problems in school which can affect academic performance (Browne & Finkelhor, 1986; Foley, 2001; Kahn & Chambers, 1991; Knight & Prentky, 1993; O’Brien & Bera, 1986; Ryan et al, 1996; Shields, 2004). Although the behavioral problems may be linked to the aforementioned social skill deficits, Kahn and Chambers’ (1991) study of adolescent sexual offenders found that academic performance was a significant deficit for most of the youths. Of their 221 subjects, 75% were enrolled in school or training when they sexually offended, with nearly 50% in the 8th or 9th grade, and more than half of the subjects had a history of problems in school: 53% were noted as being disruptive, 30% had ongoing problems with truancy, and 39% were considered learning disabled. In Lakey’s (1994) profile of adolescent sexual offenders, Lakey described this population as being “disruptive and unmotivated” in school (p. 777).
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In 2001, Foley released a review of 64 articles on offenders with intellectual disabilities and stated she found the intellectual functioning of incarcerated juvenile delinquents was within the low average to average range. In addition, Foley claimed that failure in school was a common experience among incarcerated youth, although she did not include details on the data analysis that lead to her stated conclusions. Taking a closer look at this issue, Shields (2004) recently studied 852 youths in a comparison of sexual offenders to non-sexual offenders, and did find some marked differences: 69% percent of the youths who had committed sexual offenses had failed a grade in school, compared to 50% in the control group, a significance of 2.71 (p ≤01). The subjects of the study also had a history of demonstrating poor classroom behaviour, being suspended or expelled from school, and having poor relationships with their peers (Shields, 2004).

Cognitive Disabilities

In addition to being male with a history of dysfunctional or unstable family units, attachment problems, poor social skills, and a history of academic difficulties, a frequently noted characteristic in studies of the adolescent sexual offender is the presence of some form of cognitive disability (Baroff, 2005; Glaser & Deane, 1999; Harris & Tough, 2004; Lindsay, Smith, Law, Quinn, Anderson, Smith, Overend, et al., 2004). Baroff (2005) explained in his paper that the most significant cognitive effects of an intellectual disability are language difficulties: problems in both reading and understanding spoken language, problems in reasoning and judgments, and memory deficits.

One study, which looked at biological characteristics, revealed two major areas of impairment in this population: difficulty with receptive and expressive language, and
difficulty with executive functions (Ferrara & McDonald, 1996). They estimated that 25-
33% of adolescent sexual offenders have some type of neurological impairment, and found
23.5% of the sexual offenders, compared to 3.5% of the comparison group, had grossly
abnormal EEG’s or grand mal seizures, a finding that warrants further study. Ferrara and
McDonald (1996) also noted that one finding that is consistent in the literature is that
assessments of delinquents often shows a performance IQ which is greater than their verbal
IQ. Awad and Saunders (1991) found assaulters had significantly lower full scale IQ scores
than child molesters and non-sexual offenders, with verbal IQ scores lower than the non-
sexual offenders but comparable to the child molesters.

The normative sexuality of those with intellectual disabilities is not a commonly
accepted concept, and the “systematic denial of any sexual life for this population…leads
to a climate where all sexual expression is seen as deviant” (Harris & Tough, 2004, p. 237).
Harris and Tough (2004) went on to explain that because of the lack of consensus on what
constitutes high risk behaviour for this population, staff supervising these individuals tend
to err on the side of caution, and as a result more of these individuals are unfairly labelled
high risk than ought to be. They warn that suggestions for the imposition of vigorous
treatment and strict supervision can actually be damaging to the client who is misplaced
into a higher risk category than is warranted (Harris & Tough, 2004). Indeed, as a
psychiatric social worker, I have witnessed firsthand the detrimental influence that overly
stringent supervision can have on the socialization opportunities of persons with cognitive
disabilities.

In addition, literature regarding offenders with a cognitive disability indicates the
existence of a lack of understanding of this population. The lack of appropriate legal
representation from the time of first contact with the justice system also puts this special population at a marked disadvantage (Health Evidence Bulletin: Wales, 1999); there is evidence that the justice system may treat those individuals with an intellectual disability who committed sexual offenses more seriously than it might non-sexual offenders with intellectual disability. In an 11 year United Kingdom study, Lindsay et al. (2004) compared 106 adult sexual offenders with an intellectual disability to 78 general offenders with an intellectual disability, and found that 44% of the sexual offense cases proceeded through the justice system to a formal disposition, in comparison to 29% of the non-sexual offense cases.

*Myths about sexual offenders with a cognitive disability.* Tudiver, Broekstra, Josselyn and Barbaree (2000) identified four important myths related to sexual offending by individuals with cognitive disabilities. The first is that individuals with cognitive disabilities fall on the extremes of the sexual behaviour continuum: their behaviour is either impulsive or child-like. They explained that when the behaviour is seen as impulsive, it is seen as uncontrollable and requiring 24-hour supervision, an expensive solution that denies the person the opportunity to learn to change the behaviour. As well, if the behaviour is seen as child-like, then the problem is minimized and the person is seen as powerless, another view which negates the seriousness and accountability of the behaviour. The second myth they discussed is that persons with a cognitive disability who sexually offend children are simply interacting with peers of the same level. Persons who accept this myth see the sexual behaviour being acceptable because it is between peers, which it is not. Tudiver et al., stress that while there may be similarities between a child and an adult with
a cognitive disability in respect to mental age, the differences in size, life experiences and available choices are markedly different.

The third myth addressed by Tudiver et al. (2000) is that persons with a cognitive disability cannot understand that the sexual behaviour is wrong. Tudiver claims most of these offenders can tell right from wrong in most other areas of their life, and this myth results in “a restrictive rather than rehabilitative solution” (p. 5). However, more recently, Baroff (2005) stated that many persons with a cognitive disability might know they have done something wrong because of the reactions of others in response to the behaviour, but if asked to give a reason why the behaviour was wrong, few of them would be able to do so. Finally, the fourth myth Tudiver and associates presented is that persons with a cognitive disability cannot benefit from treatment. They countered that while the research is limited, results from the literature has shown that specialized treatment reduces recidivism, and acceptance of this myth denies the individual the opportunity to benefit from appropriate interventions and to re-integrate into the community (Tudiver et al., 2000).

Likelihood to offend. Still, the question exists, “Are persons with intellectual disabilities more likely to offend than those without an intellectual disability?” Holland, Clare and Mukhopadhyay (2002) explored the prevalence of criminal offending by persons with cognitive disabilities, and found they tended to be male, younger than the non-disabled offending population, had been abused or victimized by family members, and had a history of severe psychosocial disadvantage. Holland et al. also found the population fell into one of two primary groups. The larger first group was comprised of those people with intellectual disabilities as well as social disadvantage and poor mental health. Community
service providers knew members of the second, and smaller, group, but members of this group had problems accessing services because their challenging behaviours were often labelled offending behaviours, thereby restricting agency involvement. The unclear distinction between challenging behaviour and offending behaviour in those with cognitive disabilities, as examined by Holland et al (2002), indicates that errors in labelling could result in an unrealistic picture of this population, as shown by the causal view of Australian researchers Glaser and Deane (1999) who stated:

Even now, there is no lack of evidence seemingly attesting to the criminal propensities of the intellectually disabled; witness the large number of studies that have consistently demonstrated the high incidence of intellectual disability in offender populations in the United States (MacEachron, 1979; Noble & Conley, 1992; Veneziano, Veneziano, & LeGrand, 1996), Canada (Endicott, 1991), the United Kingdom (Lyall et al., 1995), Denmark (Svendsen & Werner, 1977), and Australia (Hayes & McIlwain, 1988; Jones & Coombes, 1990) (p.338).

However, a review of the literature on offenders with an intellectual disability found contrasting opinions. Gilby, Wolf and Goldberg (1989) examined the sexual behaviours of mentally and non-mentally handicapped adolescents, and found no significant difference in the frequency of problems according to intellectual functioning level. They surmised that the higher-than-average reports of sexual offending behaviour by mentally handicapped persons was associated the higher-than-average level of supervision. In the United Kingdom, Simpson and Hogg (2001) found there was no solid evidence that persons with an intellectual disability offend at a higher rate than those of the general population; but of those persons with intellectual deficit who did offend, charges for sexual offending, damage, and burglary were most common. Similar to findings in North American studies, Australian researchers Nankervis, Hudson, Smith, & Phillips (2000) found that in comparison to non-disabled sexual offenders, those with intellectual disability
were “less likely to commit offenses that involve penetration or physical violence...more likely to engage in opportunistic and impulsive offenses...[and] more likely to select victims more vulnerable than themselves...” (p. 5).

O’Callaghan (2004) summarized a review by saying that individuals with intellectual disabilities do not offend at any greater frequency than the general population, but sexual offending is over represented in this group of offenders, adding that the over-representation “may be due to a number of factors including imprecise use of the term intellectual disability, difficulties in assessment of learning disability, and the impact of adverse life experiences, such as trauma and neglect, on many young people’s psychosocial and educational development” (pp345-346).

Effects of gestational exposure to alcohol in the offender population. In 1999, Fast, Conry, and Looke released one of the first studies performed assessing the prevalence of fetal alcohol exposure in the youth criminal population. They conducted the study on youths admitted to the Youth Forensic Psychiatric Services (YFPS) inpatient assessment unit, located in Burnaby, BC. Whereas many youths involved with the justice system are referred to one of the YFPS outpatient clinics for a court-ordered assessment, some youths are determined to be more suitable for an inpatient assessment, where data on the youths’ functioning can be directly observed on a 24 hour basis for a few days, rather than for simply a few hours, as is the case in the outpatient clinics. The inpatient assessment is typically recommended to provide a closer look at the youths’ overall functioning, especially for youths with histories of severe behavioural problems or mental illness.

Staff at the inpatient assessment unit had noted that a number of youth admitted to the unit exhibited signs of gestational exposure to alcohol. To determine if there was an
over representation of these youth, 287 youths admitted to the unit during a one-year period were assessed for evidence of gestational exposure to alcohol. At the end of the year it was discovered that over 67 of the youths had a fetal-alcohol related diagnosis: three had full spectrum fetal alcohol syndrome (FAS), and 64 had fetal alcohol effects (FAE), including those with alcohol neuro-developmental disorder. The average age of the youths studied was 14.8 years. These 64 youths with fetal alcohol diagnoses represented over 23% of the youths seen during the year, a percentage that was 10 to 40 times the accepted worldwide incidence, and only three of the subjects had been previously identified in the community as being affected by gestational exposure to alcohol (Fast et al., 1999).

Although the sample population represented many of the more challenging youth processed by the Youth Courts in British Columbia, the high rate of gestational exposure to alcohol witnessed in the population indicates a need for better understanding of how this characteristic affects youth in our adolescent offender population.

One United States study that addressed that need directly was that of Hunter (2004). Hunter explained that FAS and FAE youth could be expected to have global, rather than specific, neurological damage resulting in difficulties in attention, processing, retention, recall, and impulse control. They can also be expected to struggle in treatment and learning environments due to the difficulty experienced in generalizing learning across different situations, weak problem solving skills, and low frustration tolerance. These deficits are often highlighted in social situations where their weak empathy skills, failure to recognize social cues and the personal boundaries of peers, and their low self-esteem lead them to seek acceptance from easily joined, but negative, peer groups. This puts FAS/FAE youth at
higher risk for psychosocial behavioural problems, including inappropriate sexual behaviour.

The lack of attention given to the criminality of mentally handicapped persons leads to an over representation of mentally handicapped offenders being incarcerated, where they are often targets for abuse by other inmates and, in some countries, denied mental health services (Hodgins, 2002). In 2002, Timms and Goreczny published a literature review on adolescent sex offenders with mental retardation. Their findings painted a grim picture of the experiences of persons with mental disabilities. It showed that, for centuries, mental retardation and mental illness were viewed as joined elements resulting in persons with mental retardation being denied the rights afforded to non-disadvantaged members of society (Timms & Goreczny, 2002).

More research is needed to increase our understanding of the associations between cognitive deficits and offending behaviour. The need to address the mental and emotional health of persons in conflict with the justice system is also beginning to receive more attention from researchers. Research focusing on youth who commit sexual offenses, on characteristics of learning disabled adolescents, and on the education of those with special needs are beginning to merge, resulting in examination of the assessment and treatment of learning disabled sex offenders (Ashman & Duggan, 2003; Boer, Tough & Haaven, 2004; Hunter, 2004).

As the need to provide treatment to this population becomes more urgent, clinicians face the need for empirical research to validate their practice (Ryan, 1999). Righthand and Welsh (2001) conducted an extensive review of the literature on adolescent sexual
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offenders, and it revealed lack of research that focused specifically on the areas of
cognitive deficits in juvenile sex offenders, echoing the need for further studies in this area.

Mental and Emotional Health

Enquiring if the emotional intelligence of sexual offenders differed from a general
population of non-offenders, researchers had two groups of adolescents, those with and
those without a history of sexual offending behaviour, complete a battery of tests
(Moriarty, Stough, Tidmarsh, Eger & Dennison, 2001). They determined that there were
few significant differences between the groups. Contrary to the later findings of Lindsay et
al. (2004), the sexual offenders' results showed higher levels of aggression, but similar
deficits in understanding emotions. Moriarty and associates also pointed out that their
results indicated no significant differences between the two groups in respect to social
isolation or levels of empathy, contrary to prior research findings, although it must be noted
that their study included a sample of only 15 subjects.

Carpenter, Peed and Eastman (1995) conducted a study of 36 male adolescent
sexual offenders, divided into two mutually exclusive groups dependent on the age of
victim. The child group contained offenders whose victims were under the age of 12 and
who were a minimum of three years younger than the offender. The victims of the peer
group were aged 12 and over, and no less than two years younger than the offender. Chi
square analysis on the data revealed no significant differences between the groups in
respect to age, race, or previous sexual offenses. Carpenter et al. found, however, that the
child group scored significantly higher on schizoid, avoidant, and dependency scales, while
the peer group scores were clinically significant for narcissism. Both groups' scores were
clinically significant on the antisocial scale. Carpenter et al. suggested that their evidence supported treatment for adolescent sexual offenders that takes into account the personality differences between offenders.

Valois, Zullig, Huebner, Kammerman and Drane (2002) examined the relationship between offense patterns and the youths’ sense of happiness, and found that adolescents with low scores in life satisfaction had higher scores in sexual risk taking behaviours. Although low scores in life satisfaction and emotional intelligence may call for attention with this population, a closer look at diagnosed mental health issues in offenders reveals a more serious issue; a recent report on offenders revealed that 10% of all admissions to federal custody have a mental health diagnosis (Public Safety and Emergency Preparedness Portfolio Corrections Statistics Committee, 2004). Further, several studies that analyzed the participants’ mental health backgrounds found that over 30% of sexual offenders had a history of mental illness (Day, 1994; Glaser & Deane, 1999; Lindsay, 2002; Lindsay et al., 2004).

In comparison, a 1989 federal study of general offenders incarcerated across Canada found 10.4% had psychotic disorders, 24.5% had psychosexual disorders, 29.8% had depressive disorders, and 55% had anxiety disorders, indicating a strong need for access to mental health services in the offender population (National Crime Prevention Council Canada, 1995). In making recommendations for further research in the forensic population., Hodgins (2002) identified that very few studies exist that evaluate the impact of social services on mentally disordered offenders, a population that forensic mental health clinicians are seeing in increasing numbers. He commented,
Forensic mental health practitioners and researchers have traditionally been isolated from general mental health practice and research. Both general and forensic mental health practice could benefit from closer involvement…and promote the use of scientific research as a tool to improve the efficacy of treatment (Hodgins, 2002, p. 19).

**Offense Characteristics**

Statistics Canada (2003a) data shows that youths committed 11.8% of the aggravated sexual assaults in Canada that year, and were responsible for 16.5% of sexual assaults committed with a weapon. Although knowing the frequency of sexual offenses committed by youths provides us with some information about the seriousness of the problem, some researchers have examined the details of the sexual offenses in hopes of gaining insight into those responsible (Herkov, Gynther, Thomas, & Myers, 1996; Hornsveld & De Kruyk, 2005; Hudson et al., 1999; Kahn & Chambers, 1991; Knight & Prentky, 1993; Langstrom, Grann, & Lindblad, 2000).

**Offenders of First Nations ancestry.** Ellerby and MacPherson (2002) were curious about the differences between sexual offenses committed by those of First Nations and non-First Nations descent. They examined 303 participants, 40% of which were of First Nations descent. They reviewed the subjects' offense histories and determined that victims of First Nations offenders tended to be adults, while non-First Nations offenders had a higher rate of offenses against children, particularly incestual offenses. In addition, Ellerby and MacPherson found that the majority of victims of offenders of First Nations descent were female, while the other offenders tended to victimize both females and males.
Victim selection and victimization. The findings indicate that most adolescent sexual offenders, who begin offending in childhood or early in their adolescence, choose children that they know to be their victims, most of whom are female children under the age of 12. They tend to offend more than one victim, commit most offenses when alone with the victim, commit offenses of sexual touching involving penetration more often than sexual assault with intercourse, and are more likely to use coercion or threats instead of a weapon in the commission of their offenses. In studies of offense characteristics with offenders who had suffered prior victimization themselves, Widom and Ames (1994) conducted a study with a very small sample size that revealed that young offenders who had been physically abused were 7.6 times more likely to rape or sodomize other children when compared to young offenders who had been sexually abused or neglected.

In contrast, Truscott (1993) reviewed the histories of 153 offenders, and found that sexual offenders were twice as likely to have suffered sexual abuse themselves. Veneziano, Veneziano, and LeGrand (2000) found those offenders who had been sexually abused themselves before the age of five were twice as likely to abuse a victim under the age of five. In addition, they found that boys who had been subjected to anal intercourse were 15 times more likely to abuse their victims through anal intercourse. Although research does not support sexual abuse as a predictor of recidivism, because many victims of sexual abuse do not go on to become offenders, Veneziano et al. suggest that for a subset of adolescent sexual offenders, their offenses may be a re-enactment of their own victimization.

Substance abuse. The frequency of substance abuse by offenders at the time of the offense remains an unresolved question. In the Davis and Leitenberg (1987) study,
intoxication at the time of offense was uncommon, contrary to more recent studies by Lightfoot and Barbaree (1993) and Monson, Jones, Rivers and Blum (1998) whose data suggested that 40% to 50% of sex offenders reported they were under the influence of alcohol at the time of their offense. However, Davis and Leitenberg (1987) suggested that studies finding higher rates of alcohol influence may be the result of offenders claiming to be under the influence in an attempt to blame their behaviour on the influence of alcohol rather than accepting responsibility for their actions. Researchers reviewing this issue in 2001 concluded that “there is little agreement in the literature as to whether adolescent offenders were frequently intoxicated at the time of offending” (Pratt, Patel, Greydanus, Dannison, Walcott, & Sloane, 2001, p. 3).

Offender types. Researchers and clinicians have also examined sexual offenders based on victim selection, as well as type of offense, and have found some common characteristics. For example, Abracen et al., (2004) compared groups of child molesters, incestual offenders, and rapists, and found deviant arousal to be of assistance in identifying the type of offender: the child molesters scored higher on sexual deviance. Similarly, a Netherlands study by Hornsveld and De Kruyk (2005) looked at 105 sexually violent and 69 non-sexually violent, adult male outpatients. The average age of the sexually violent patients was 40.5 yrs, with an average of 23.4 years for the non-sexually violent patients. Hornsveld and DeKruyk found the differences in personality traits between the two groups were significant, with measurements showing sexually violent clients as more neurotic, less aggressive overall, and more socially anxious.

Salter (1998) cites numerous research articles that identify factors believed to contribute to interfamilial child sexual abuse. Some of those factors cited by Salter give
evidence to how many sexual offenders do not accept responsibility for their actions, but blame external factors such as: social isolation; unsatisfactory sexual relationship; marital discord; role reversal; a wife who is passive, colluding, powerless, or dependent; a wife who is physically, psychosomatically, or mentally ill; a sex punitive or absent mother; family dysfunction or involvement; alcoholism; or a seductive child.

Other studies, conducted in an attempt to gain a better understanding of this population, have examined a variety of different variables, including: onset of sexual offending behaviour (Brown & Kolko, 1998; Motiuk & Porporino, 1993; Ryan et al., 1996), victim selection (Moody, Brissie & Kim, 1994; Bullens & Van Wijk, 2004; Danni & Hampe, 2000; Knight & Prentky, 1993; Ryan et al. 1996; Veneziano et al., 2000), relationship to victim (Ellerby & MacPherson, 2002; Fehrenbach et al, 1986), type of sexual offense (Awad & Saunders, 1991; Davis & Leitenberg; 1987; Knight & Prentky, 1993; Richardson, Kelly, Graham, & Bhave, 2004; Poropino & Motiuk, 1991), and whether or not the offender was under the influence of drugs or alcohol at the time of the offense (Lightfoot & Barbaree, 1993).

Pendergast (2003) provided a summary of many of the traits found in adolescents who sexually offend:

Basic inadequate personality...Negative self-image (exaggerated)... Exaggerated need for acceptance...Selective perception...Exaggerated control needs...Pervasive guilt with persistent need for forgiveness... Subjective judgment memories...Nonassertive...Poor to no interpersonal relations...No peer interaction... Emotions suppressed/displaced...Strong sexual performance needs...Small penis complex (unreal)...Distorted sexual values...Deviant arousal patterns...Defective goal-setting system...Identity confusion...Cleverness in dealing with others...Highly manipulative and controlling (p. 6).
Categorization and Typologies

As with many of the developments in the field of intervention for adolescent sexual offenders, researchers' initial attempts at classification stemmed from studies of the adult sexual offender population. Researchers categorized sexual offenders into subgroups, based on offense variables, in an attempt to determine a consistently reliable and valid classification system. The Interpersonal Maturity Level Classification System, also called the I-level [short for Integration level] is the most thoroughly researched classification system used for subdividing offenders by personality type, and was developed between 1961 and 1975 by Marguerite Warren and her associates for use at the Community Treatment Project of the California Youth Authority (Harris, 1988). Not initially intended for use with delinquents, the I-level began as a project by Berkley psychology students in the 1950s. Harris went on to explain that it was Marguerite Warren that added empirically derived subtypes to the developmental stages of the original model, although four stages are typically used when assessing adolescents, and it is primarily a treatment-planning tool.

Motivation for committing the sexual offense was another of the first variables used to develop a classification system. In 1964, Gebhard and Gagnon labelled adult offenders as either patterned or incidental; patterned offenders were those with a pattern of attraction to a specific victim type, usually children, whereas the offenses of incidental offenders were influenced more by external stressors. The next model to gain popularity was that of Groth (Berger, 1995; Birnbaum & Groth, 1978). Groth introduced a fixated-regressed classification for offenders of children. Fixated offenders usually premeditate their crimes, and their offenses usually begin prior to adulthood. They also have a persistent attraction to children, often including a diagnosis of pedophilia (see Appendix 3). The fixated offender
is characterized by few age-appropriate relationships. He is also more likely to select male victims of no relation. The regressed offenders, on the other hand, are influenced more by external stressors and offend a child out of convenience, although they prefer age-appropriate partners. Their offending behaviour does not typically begin until adulthood and they are not motivated by sexual urges alone. Similar to Gebhard and Gagnon's (1964) model, Lanyon (1986) also differentiated between those offenders who prefer children and those offenders who sexually offend a child out of convenience.

Although Lanyon's (1986) approach was once widely accepted, it has come under criticism due to the dichotomous label it forces. Simon, Sales, Kaskniak, and Kahn (1992) conducted a study to examine the construct validity of the fixated-regressive dichotomy with 136 sexual offenders. Their results did not show a bimodal distribution, as would be expected for the fixated and regressed representation; instead, a unimodal and continual distribution emerged. This finding, showing the offenders to be neither fixated nor regressed but within a continuum between the two labels, brought about further investigation of offender typologies (Terry & Tallon, 2003).

In 1986, O'Brien and Bera developed a comprehensive typology specific to juvenile sexual offenders. They based their model of seven categories on the youth's characteristics, behavioural history, offense history, family dynamics, and the motivations for sexually offending. Their first category is the naive experimenter. The naive experimenter is a younger teen from a healthy and relatively stable family background. He has little history of problem behaviours. Motivated primarily by curiosity, he takes advantage of a presenting opportunity with much younger children. Planning is seldom involved and there is little, if any, use of force or threats. The under socialized child molester falls into the
second category. The under socialized child molester is socially isolated and lacks sufficient social skills to develop positive age appropriate peer relations, so tends to seek out acceptance from much younger children. He rarely has a history of acting out behaviours or substance use. He may have multiple victims of both sexes, and is more likely to use manipulation or coercion to gain victim compliance.

The *pseudo-socialized child molester* is likely to appear as an intelligent, socially competent, and charming youth. However, after longer exposure it is discovered that he is arrogant, manipulative, and self-centered. He often has a history of lying, and is likely to have some history of substance use. His multiple victims may be male or female, and he shows little empathy for his victims, describing them as being consenting partners. Repeated pleasure received from offending behaviour may lead to more entrenched deviant arousal patterns, and he will tend to use sexual offending behaviours to alleviate stress and meet non-sexual needs. Parents of the pseudo-socialized child exploiter may reinforce this youth’s behaviour by supporting his lack of personal accountability (O’Brien & Bera, 1986).

O’Brien and Bera (1986) described a youth in their fourth category, the *sexually aggressive offender*, as being charming and gregarious, although he displays a variety of school, community and family misbehaviours. He typically has a severely dysfunctional family system, and the local authorities likely know him due to his anti-social behaviours, which often include substance use. He has a wide range of victims, and the offenses are characterized by aggression, including force, threats, and manipulation. He lacks remorse and disregards the victims’ pain. He uses his sexual offending behaviour to gain a sense of control and power in addition to meeting his own sexual needs. A youth in this fourth
category can become quite dangerous if he begins to derive sexual pleasure not only from the sexual offense, but also from the violence used in the act, as then there exists the likelihood of increasing acts of violence in his attempts to gain increased sexual pleasure.

O’Brien and Bera (1986) state that the repeated sexual behaviours of a youth in the fifth category, the sexual compulsive, are often non-contact offenses such as voyeurism or exhibitionism, although he may also engage in “accidental” frottage, or blatant sexualized behaviours followed by masturbation, which reinforce the deviant arousal. This type of offender usually has a rigid and enmeshed family structure, and uses his planned offenses to reduce feelings of tension or anxiety. Unlike the premeditated offenses of the sexual compulsive, the disturbed impulsive offender of the sixth category is socially isolated with poor impulse controls, sometimes due to psychological disturbance. His victims may be adults or children, and his offenses may range from solitary incidents to ritualized acts. Finally, the seventh category is the group influenced offender. O’Brien and Bera state that the offenses of this type of offender are group-motivated. The group influenced offender abides by the instruction of peers in order to gain their acceptance or attention. He typically has no significant history of criminal activities or mental health concerns. This type of offender has adequate social skills, but, as is the case with youth from the other six categories, has inadequate empathy and judgement (O’Brien & Bera, 1986).

Although comprehensive, O’Brien and Bera’s (1986) typology has been described as being of heuristic value due to its weighted reliance on the clinician’s appraisal of the youth (Langstrom et al., 2000). Quay (1987) points out that research has repeatedly shown that juvenile delinquents are a heterogeneous group, so research attempts to identify delinquents with a single variable is an ineffective strategy, as are attempts to find a
singular cause for the delinquency. Instead, Quay proposed that the more attractive solution is to identify subgroups of the population who are homogeneous in respect to some behavioural and psychological characteristics, and he adds that those subgroups must be “reliably observable, describable from one another, reasonably frequently found among delinquents, and related in different ways to variables relevant to causes, treatments and consequences” (Quay, 1987, p. 120). Following Quay, Knight and Prentky (1993) examined the classification of juvenile sex offenders using adult sex offender classification variables and they identified the need for adolescent-specific taxonomy. However, a nationally accepted taxonomy system has yet to be established.

In 1996, Graves, Openshaw, Ascionce and Erickson conducted a meta-analysis based on type of offender. They defined pedophilic offenders as those who commit their first sexual offense between the ages of 6 and 12 and consistently offend younger children, while they defined sexual assaulters as those whose first offense was reported between ages 13 and 15 and who commit their offenses against victims of varying ages. The justification for basing the determinant variable on when the offenses were reported is not provided. This raises the question of whether or not some youths included in their sexual assaulters group had, in fact, commit their first offense prior to age twelve, but the early offenses were not reported, thereby blurring the distinction between their groups.

In another study based on grouping the subjects based on characteristics, one Canadian doctoral student studied 588 sexual offenders seen at the Royal Hospital in Ottawa between 1983 and 1992. McCoy (1997) divided the sample into four groups: members of the Incest Group had sexually assaulted a related child under 16 years of age; Child Molester Group members had sexually assaulted an unrelated child under the age of
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16; Rapist Group members had committed a sexual assault against an unrelated female over the age of 16; and members of the Mixed Group had sexually offended against both related and unrelated children, or against both an adult female and a child. McCoy found the characteristics of the members of the four groups in the typology to be significantly different in terms of demographics, criminal and psychiatric history, substance abuse, and offense specifics, once again emphasising the heterogeneity of this population.

In an attempt to find homogenous characteristics in rapists, the Massachusetts Treatment Centre Taxonomic Program developed the Massachusetts Treatment Centre rapist Typology (MTC:R) (Knight & Prentky, 1993), as shown in Figure 1 (p. 53). This typology categorizes adult rapists into one of nine types based firstly on one of four primary motivation types: opportunistic, pervasively angry, sexual, or vindictive. Opportunistic offenders tend to commit impulsive acts influenced by context and situation (Knight, 1999). These types of offenders are subdivided based on their social competence level: high (Type 1); or low, (Type 2). Pervasively angry offenders, (Type 3), express frustration through violence, have histories of aggressive behaviour, and rape is another manifestation of their aggressive behaviour. The typology divides rapist sexual offenders into sadistic and non-sadistic categories based on the presence, or absence of, sadistic sexual fantasies.
The sadistic offenders, whose frustration is aggressively sexualized, are further divided based on whether their violent sexual fantasies are directly acted out (Type 4), or are only fantasized, (Type 5). The non-sadistic offenders are classified by their social competence level of high (Type 6) or low (Type 7), as are the vindictive offenders (Types 8 and 9, respectively) (Knight, 1999). The 1999 study on the validity of the MTC:R3 included a paper-and-pencil inventory of 541 questions and statements based on the MTC:R3 put to 254 subjects. The results were unable to identify whether taxonomic or multidimensional models were more valid, and Knight spoke to the need for more empirical research to address the controversy of employing a taxonomic or multidimensional model, or a combination of both, to explain sexual offending behaviour (Knight, 1999).

Richardson et al. (2004) identified that most studies on sex offenders characterize the adult population by personality, and characterize the adolescent population by
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description of behaviour. Occasionally, the labels assigned in these cases can be misleading. For example, in a 1986 study, Becker, Cunningham-Rather and Kaplan identified adolescent sexual offenders with victims under the age of five years as pedophiles, and those with victims over the age of five years as rapists, terms that have diagnostic implications.

One of the first research studies to examine the personality characteristics of adolescent sexual offenders was in 1987, when Smith et al. assessed 262 outpatient juvenile sexual offenders using the Minnesota Multiphasic Personality Inventory (MMPI). They discovered four distinct profile groups. Those in group one were immature, had a normal range profile, were socially unskilled, and were trying to present themselves as blameless. Members of group two were personality disordered, with very disturbed profiles. They were narcissistic, demanding, disagreeable, and had frequent somatic complaints. Those in the third group were more socialized and their scores were within the normal range; they were extroverted, but likely to be dominated, and had poor emotional self-control. Members of the fourth group had abnormal scores, were conduct disordered, impulsive, under socialized, and demonstrated poor judgement (Moody et al., 1994).

Oliver, Nagayama-Hall, and Neuhaus (1993) pointed out that in the study by Smith et al. (1987), the data was analyzed in a unique manner by using factor analysis on the MMPI scale scores, thereby creating non-pathological profile subtypes. They noted that until other studies use this technique, the results found in the Smith et al. study could not be confirmed (Oliver et al., 1993).

In 1998 the research into classification models continued when Pithers, Gray, Busconi and Houchens studied children aged six to twelve, and listed five sexually
misbehaved types: rule breaker, abusive reactive, highly traumatized, nonsymptomatic, and the sexually aggressive (Pithers et al., 1998).

In an effort to fill a gap in the literature by empirically examining the families of adolescent sexual offenders, Falls (2001), a student at the University of Toronto, focused her doctoral thesis on the development of a typology. She discovered five distinct types of families: Extremely Problematic, Structurally Unstable, Multi-Problem, Healthy, and Problematic Parenting. Through cluster analysis, Falls found that all of the adolescent sexual offenders from Extremely Problematic families had been sexually abused themselves; all had offended against a child, the majority of victims being male and siblings; and their sexual acts were more diverse than those of the other groups were. Offenders from the Structurally Unstable families had the highest rate of permanent separations from their parents, chose primarily female victims (70%), and used some level of violence in their offending. Multi-Problem families were characterised by alcohol abuse, criminal activities, inconsistent parenting, and changes in family structure. Falls’ (2001) research revealed that the profiles of adolescent sexual offenders from multi-problem families most closely resembled those from non-sexual, violent offenders. Healthy families ranked low in each of the five variables used to differentiate the family types: family structure, family dynamics, sexual behaviours, family violence and antisociality. Further, the youths studied did not show significant differences from non-offending youths, leading Falls to suggest that other factors, such as sexual repression or denial, may be influencing these offenders. Finally, families identified as belonging to the Problematic Parenting group were characterised by frequent relationship disruptions, and high family dynamics. The majority of youths from these homes admitted to sexually deviant behaviours prior to
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their offenses (80%), offended against a female (60%), and used violence (60%). Although some similarities were found, Falls concluded that membership in a specific family type was not predictive of offense characteristics or victim selection, but noted that family disruption appeared to be the strongest influencing factor.

Supporting many of the findings of Smith et al. (1987), Worling (2001) emphasized the need for typologies to take into account more than the age of the victims selected, and proposed a four-group typology based on personality characteristics. Hunter, Figueredo, Malamuth and Becker (2003) presented a more recent attempt at classification in which they developed a typology based on three personality constructs. The first, *Psychosocial Deficits* examined levels of anxiety, depression, self-esteem and self-efficacy. The second was *Hostile Masculinity*, where the motive for the offense was dominance because of negative associations with females and prior incidences of rejection. The final construct, *Egotistical–Antagonistic Masculinity* reflected “a stereotypical masculine sex role orientation and the tendency to aggressively seek dominance in sexual competitions with other males” (Hunter et al, 2003, p. 30). The researchers correctly hypothesized that youths with significant psychosocial deficits would have offended primarily against children. However, their hypothesis that youths in the Hostile Masculinity and Egotistical-Antagonistic Masculinity constructs would have offended primarily against pubescent females was not founded; these two constructs were not predictive of offender status, but did relate to specific risk factors. The researchers noted that the sample of incarcerated youths who volunteered to participate in the research resulted in a sample that was weighted with youths who had offended against children, and the authors noted, therefore, that the sample might not have been sufficient to differentiate between the groups.
Richardson et al. (2004) re-addressed the need for studies on the personality characteristics of adolescent sexual offenders by publishing a study on the scores obtained from the administration of the Millon Adolescent Clinical Inventory (MACI) to 112 adolescent sexual offenders. Richardson et al. stated their data revealed prototypes based on the personality pattern scores, and that those groups could be further divided on their scores for expressed concerns and clinical syndromes. Using a five-factor cluster analysis, they found five subtypes: normal, antisocial, submissive, dysthymic-inhibited, and dysthymic-negativistic. They concluded that a strong link did not exist between client profile and offense type, but put weight in their finding of the five profiles. They went on to state that if the MACI profiles are accurate, there is reason to question the appropriateness of offense-specific treatment groups in favour of groups formed on the basis of personality type and clinical presentation. Moody et al. (1994) compared youth who sexually offended to those with oppositional defiant disorder found the sexual offenders were less intelligent, more self-indulgent, demanding of attention, impatient, and had academic problems, but scored higher academically than youths with oppositional defiant disorder.

Vizard, Monck and Misch’s (1995) review of the literature on sexually offending youth determined that there is lack of agreement on how offending and non-offending adolescents differ. Some research has demonstrated that sexual offenders are a heterogeneous group (Blanchette, 1996; Gordon & Porporino, 1990; Quay, 1987; McShane & Williams, 2003; O'Shaugnessy, 2002). Longo and Groth (1983) convey how sexual behaviour among adolescent sexual offenders is different from adolescent non-offenders; however, other studies have found that non-offenders also admit to deviant sexual
behaviour (Briere & Runtz, 1989). Burke (2001) explained that the lack of understanding on what constitutes normal adolescent sexual behavior complicates this issue. Davis and Leitenberg (1987) concur:

"...although there is considerable clinical lore about the forces that motivate adolescents to commit sexual offenses, studies involving matched comparison groups are almost entirely lacking. We do not know if adolescent sex offenders truly differ from normal adolescents or from other delinquents who have never committed a sexual offense on a host of variables that have been clinically implicated but never empirically investigated in a controlled fashion. These include such obvious variables as insecurities about masculinity, sexual performance fears, rejection fears, social skills deficits, hostility toward women, fears of adult homosexuality, stereotyped sex role attitudes, and atypical masturbation fantasies (p. 425).

Harris and Jones (1999) examined the numerous classification systems and concluded that categorization meets one of four purposes: to give insight into the population, to more effectively match client to intervention, to allow for better management of the offender, or to predict behaviour in order to reduce risk of reoffense. Further development of typologies is needed in order to better tailor treatment and intervention to the youths’ specific needs (Becker, 1998). Until research is able to provide a definite means of determining all the ways in which an offender differs from a non-offender, clinicians will need to rely heavily on identification of the individual treatment needs of the client as revealed through a comprehensive assessment.

Pre-treatment Assessments

The psychological assessment of a sexual offender typically consists of eight areas of functioning: life history, sexual behaviour, social functioning, cognitive processes, personality, substance abuse, physical problems and relapse-related issues (Marshall, 1999). In addition to providing valuable information for clinicians and researchers on the
characteristics of this clientele, assessments of sexual offenders play an important role for the community. The justice system uses assessments of these clients to determine the client’s ability to understand the court process, and to gain insight into the client’s behaviour in order to apply appropriate interventions while reducing risk to the community.

Assessment Types and Their Purposes

To assist in understanding the types of assessments referred to in the literature review, this section includes a description of the assessment types and their purposes. Youth Forensic Psychiatric Services (YFPS) receives four primary types of referrals for assessments, each serving a specific purpose. Three of the assessment types are requested by the court and a court order is issued requiring the youth to attend YFPS for the purpose of a fitness assessment, a bail assessment, or a pre-disposition assessment. A supervising probation officer may issue a request for the fourth type, and direct the youth to attend YFPS for the purpose of a post-sentence (or “post disposition”) assessment. In addition, when the judge or probation officer identifies specific questions to be answered, such as “The youth has a history of head injury - is it a factor in his criminal behaviour?” or “The youth has a history of deviant behaviour. What would assist this youth to succeed in the home and community?” the assessment can focus specifically on providing the most helpful information to the court (Dr. D. O’Toole, personal communications, 2004).

Fitness assessments. The first type of assessment the court may request is the fitness assessment. The fitness assessment determines the youth’s capacity to understand the offense and his suitability for trial. A doctor of psychiatry, based on an interview of the youth, conducts this type of assessment. The doctor often completes this type of assessment
within one or two hours. If the psychiatrist determines that the youth is unable to understand the court process, unable to understand the possible consequences, or unable to give direction to his lawyer for his own defense, the youth is determined to be "unfit to stand trial" (Unfit). If the youth is found to be suffering from a mental disorder that results in him being unable to understand that his actions were wrong, he is determined to be "not criminally responsible due to a mental disorder" (NCRMD). Youths determined to be NCRMD or Unfit are placed under the jurisdiction of the Review Board of British Columbia.

Based on assessments of the risk to the community and the best interests of the youth, the Review Board must decide to either place the unfit youth in custody, or to discharge him under conditions that restrict his freedoms until he is ascertained to be able to understand the court process, understand the consequences, and can direct his counsel. At that time, the youth returns to court to deal with the matter. If the youth is determined to be NCRMD, the Review Board must decide to (i) provide the youth with an absolute discharge (similar to a full pardon); (ii) remove the youth from society by holding him in custody or, more typically, a psychiatric care facility; or (iii) release the youth to the community under conditions restricting his freedom and requiring his participation in treatment or programming. The Review Board then revisits the matter at least once per year to reassess the youth and his risk to the community and himself.

*Bail assessments.* The second type of assessment that the court may request is the bail assessment. This assessment provides the court with information on the youth’s risk to the community and himself, and provides the court with information to consider when determining whether or not to release the youth to the community while he awaits trial.
Due to the short time limits imposed on bail assessments, the assessing doctor of psychiatry or psychology reviews only those items already available to meet the bail assessment purpose, such as the youth's criminal history, history of RCMP involvement, history of aggression, level of responsibility, level of empathy, drug and alcohol use, and placement stability. The tight time limitations on the bail assessment do not allow for as comprehensive assessment as that of the third type of court ordered assessment, the pre-disposition assessment 4.

Pre-disposition assessments. At YFPS in Northern British Columbia, the pre-disposition assessment of a youth who sexually offends characteristically includes three assessment components: psychosocial, psychometric, and psychological. A psychiatric social worker or psychiatric nurse prepares the comprehensive psychosocial assessment. The clinician preparing the psychosocial assessment gathers information for the report, with the youth's written consent, from collateral sources. The information gathered includes files of the birth hospital, schools, physicians, prior assessors, government services, and community agencies. In addition, the clinician conducts an extensive interview with the person/s that provided primary care to the youth, usually the parent.

The psychosocial assessment report provides the court with information on the youth's developmental, educational, medical, social and familial history, and identifies for the court the available resources for intervention and support services, based on the assessed needs of the youth and his family. In Northern British Columbia, the psychosocial assessment is not incorporated into a single doctor's assessment report, as is done in other areas of the province, but instead is submitted to the court as a separate document by the

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4 Although the correct term is pre-sentence assessment, this term is often confused with the non-psychological pre-sentence report the court may order a probation officer to prepare to provide information on the youth's background, appropriate conditions for supervision, and available community resources.
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author. This is of assistance to the court in those cases where providing a copy of the doctor’s assessment to the youth, which has incorporated the psychosocial assessment including information not known to the youth about the family history, would be detrimental to the youth’s well-being. In addition, because some youth court judges in British Columbia travel from community to community to hear cases, the information contained in the psychosocial assessment about the available resources in the community and the eligibility of the youth to access those resources is important to those judges who are not familiar with the community in which they are sitting (Hon. Judge M. Brecknell, personal communications, 2004; Hon. Judge P. Meyers, personal communications, April 5, 2006).

The second component of the pre-disposition assessment is a psychometric assessment. This assessment, conducted by a psychological assistant, requires the youth to complete a series of standardized psychological tests and inventories that explore the youth’s personality, as well as academic, problem solving, and comprehension abilities. The psychological assistant submits the results of these tests to the psychologist for inclusion in the doctor’s assessment report.

The third component of the pre-disposition assessment is the interview conducted by a doctor of psychiatry, a doctor of psychology, or both. The doctor uses the psychosocial assessment information, the psychometric testing results, and a personal interview with the client to assess, typically, eight areas of functioning: sexual behaviour, social functioning, life history, cognitive processes, personality, substance abuse, physical problems, and assessment of the youth’s risk to reoffend Marshall (1999).
Diagnoses are determined as specified in the Diagnostics and Statistics Manuals (DSM) (American Psychological Association, 1994; 2000), with consideration to recent changes in the criteria for diagnosis of a paraphilia (see Appendix 2). In version four of the DSM (DSM-IV), the second criterion for diagnosis of a paraphilia was, "The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 523). This wording prohibited diagnosis of the paraphilia if the client was not distressed by his behaviour, a significant change from previous versions in which simply acting on the urges was sufficient for diagnosis. It is important to note that this latest text revision of the (DSM-IV-TR) acknowledges that the client may not be distressed by the behaviour, but still qualifies for the diagnosis if he has acted on the urges. Debate continues on the appropriateness of the DSM continuing to include criteria for a paraphilia diagnosis (Moyser & Kleinplatz, 2003).

At the completion of the three components of the pre-disposition assessment, YFPS forwards the assessment package directly to the court, which is responsible for distribution of the assessment to those persons eligible to receive a copy, as specified in the Youth Criminal Justice Act. The judge may then consider the information within the assessment package when determining the most appropriate sentence for the youth, and the judge is then better prepared to impose probation conditions which best support the rehabilitation of the youth. For instance, if the assessment determines that the youth would benefit from participation in the YFPS sexual offense treatment program, the judge may give the youth a condition which states the youth must attend, participate, and successfully complete the YFPS sexual offense program, which is the preferred condition for acceptance to the program. In addition, if the youth resides in a community which is out of commuting
distance, the judge may give the youth a condition which states the youth must reside and participate in a residential attendance program if referred to one by his probation officer, a condition which makes the youth eligible for government sponsored placement in a residence in the treatment community without expense to the youth's family. Without such a condition on the youth's release from court, the youth may not be able to access the necessary services for effective rehabilitation. In addition, without the commission of a new offense, conditions necessary for participation in some programs cannot be added to a youth's order if doing so would make the order more onerous. Therefore, a pre-disposition assessment is of significant importance to ensure the best interests of the youth and his family are accurately addressed in the sentence provided by the judge.

*Post-sentence assessments.* The fourth type of assessment, the post-sentence (or "post-disposition") assessment may be requested by the supervising probation officer. At YFPS, the post-sentence assessment provided to the probation officer contains the same components as would a pre-disposition assessment provided to the court. Probation officers typically request this type of assessment when the youth completed the court process without the judge ordering a pre-disposition assessment, and the supervising officer faces the difficult task of trying to plan effective interventions with little understanding of the reasons for the youth's behaviour. This assessment also assists the probation officer in determining which types of services would best meet the youth's individual rehabilitation needs for reintegration into the community, without supervision, at the completion of the probation order.

However, when a judge sentences a youth without the benefit of a pre-disposition assessment, the resulting order often lacks the necessary conditions to access those services
recommended in the post-sentence assessment (K. Culbert, probation officer, personal communications; V. Pike, probation officer, personal communications; H. Resch, probation officer, personal communications). Therefore, it is important that the assessment report includes specific information on the individual characteristics and needs of the client. Many of these characteristics are determined with the use of standardized measures.

Assessment Tools

Bemet and Dulcan (1999) observed, “There are no specific empirical measures or psychological tests that can identify, diagnose, or classify sexual abusers, although psychological testing may be used adjunctively to understand the personality traits, sexual behaviors, and intellectual capacities of these youngsters” (p. 5). In order to determine the individual characteristics and needs of the client, the psychologist may request that the client complete one or more tests to assist in the assessment. With a vast selection of tests available for use, the psychologist will specify which tests are required based on their personal preference, on the individual needs of the client, and on the specific question on the referral for assessment.

While psychological tests do not replace the importance of findings from a psychological interview (Bemet & Dulcan, 1999), many of the studies on characteristics of this population are based on the outcome of data from the use of these assessment tools. Referring to an early study which described 29 tests being used in 113 studies to correlate personality and delinquency (Scheussler & Cressey, 1950), Arbuthnot, Gordon and Jurkovic (1987) claimed that since 1950, researchers have been attempting to determine if offenders differ from non-offenders, and if so, how they differ. In an attempt to answer that
question, researchers and clinicians have utilized a variety of tools for assessment. For example, Csercsevits (2000) used Rorschach testing on 184 male adolescents: 60 adolescent sexual offenders, 71 adolescent non-sexual offenders, and 44 adolescent non-offenders. Csercsevits found that the adolescent sexual offenders had significantly higher scores than the other groups for the number of responses, and suggested that the Rorschach test may be useful in discriminating among the groups, as it indicated that the sexual offenders had higher levels of negative, aggressive characteristics than those in the other two groups.

Six of the many standardized tests that have been utilized for assessment purposes in the northern Youth Forensic Psychiatric Services clinic include: (i) the Wechsler Intelligence Scale for Children (WISC), (ii) the Wechsler Adult Intelligence Scale (WAIS), (iii) the Wechsler Individual Achievement Test (WIAT), (iv) the Minnesota Multiphasic Personality Inventory (MMPI), (v) the Jesness Inventory – Revised (JI-R) (Jesness, 2003), and (vi) the Millon Adolescent Clinical Inventory (MACI). For the purposes of this study, data from the WISC, WAIS and WIAT were collected.

*The Wechslers.* The first intelligence assessment tool developed by David Wechsler, then a psychiatrist at the Bellevue psychiatric hospital in New York (Nell, 1994), was called the Wechsler-Bellevue Intelligence Scale. Published in 1939; it was based on scales from the Stanford-Binet, and was intended to be used to assess general abilities in adults. Ten years later, the Wechsler Intelligence Scales for Children (WISC) was first released in 1949, followed by revisions in 1974 (the WISC-R), and again in 1991 (the WISC-III) (Edelman, 1996). The WISC is the most popular intelligence scale used in

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5 The WISC, WAIS, WIAT, MMPI, JI-R, and MACI are registered (®).
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schools (Silverman, 2006). The Wechsler Adult Intelligence Scale (WAIS) is used for those 17 years and older (Zhu, Weiss, Prifitera, & Coalson, 2004).

The Wechsler Individual Achievement Test second edition (WIAT-II) is intended for use with those aged 4 to 85 years, in grades pre-kindergarten through college. The test measures academic skills in written and oral language, reading, and mathematics (Harcourt Assessment Company, 2002).

**Assessment of Those with Cognitive Disabilities**

As explained previously, assessment reports provide insight into the youth, his background, his motivations, and often provide recommendations for appropriate community interventions. With youths who have cognitive disabilities and sexually intrusive behaviour, identification of the disability at the onset of their involvement in the justice system becomes even more important to the youth’s future (Brodsky & Bennett, 2005; McBrien, 2003; O’Brien, 2001). Despite the importance of determining the youth’s understanding and abilities, the identification of a cognitive disability has been a contentious issue for many years, for several reasons.

*Assessment risks to the clients.* First, there is the ethical issue facing the assessors whose professional governing bodies expect members to “do no harm” to the client. This principle falls into direct conflict with the expectations of the justice system when the assignment of a label or diagnosis, or the lack thereof, can result in a negative outcome for the client. One extreme example of this ethical dilemma stems from the decision of the United States Supreme Court (2002) where “the Supreme Court held that the execution of any individual with mental retardation violated the Eighth Amendment’s prohibition on
cruel and unusual punishment” (p. 2). For clinicians assessing clients that face the death penalty, this court decision puts them in the unenviable position of knowing that if they issue a report stating their client is not mentally retarded, their client will be executed. For less extreme cases, the determination in assessment of a previously unrecognized cognitive disability may result in access to more services for the client, but can also result in the client being assigned a diagnosis label that may result in segregation from peers in academic settings.

As mentioned, some professionals hesitate to assign a diagnosis that will become a label, for fear of marginalization or lower self-esteem for the client. The Canadian Community Living Foundation (2006) has funded projects to educate the public on how to replace negative terms with the more politically correct identification of the person followed by the explanation of their difficulty, such as _person with intellectual impairment_. Ironically, client access to many educational and social services are dependent on the client receiving a specific diagnosis from a particular type of professional in order to meet the criteria for service. For instance, in order to receive services from Community Living British Columbia (CLBC) (2006), the government agency responsible for provision of services to those with cognitive disabilities, the applicant must first be diagnosed with a _developmental disability:_

... measured intellectual functioning of approximately 70 IQ or lower, with onset before age 18, and measured significant limitations in two or more adaptive skill areas. Eligibility criteria reflect the internationally accepted definition of developmental disability including IQ measurement of 70 [with a standard error of 3-5 points] and the key role adaptive skills play in both the definition and determination of eligibility for services (Community Living British Columbia, 2006, ¶8).
Without this designation, the applicant does not qualify for many services, such as housing, financial support, assisted independent living, or even assistance in accessing other community services. If the assessment reveals that the client meets the criteria for intervention or community services, in addition to any expectations imposed by the court, the client often faces a myriad of paper circles in order to apply properly to the correct agency for assistance, a formidable task for even a non-disabled person.

This problem compounds when the youth with a cognitive disability exhibits violent or sexually intrusive behaviours. Many community mental health agencies will redirect these clients to other services, stating they do not have the expertise needed to address the issues of the offending behaviour, resulting in some parents having their children arrested in order to access mental health services available in the justice system (Grisso, 2006). Grisso went on to warn that this practice has the potential to turn the youth justice system into a mental health system, thereby ignoring the intended role of the juvenile justice system. In a longitudinal study of 449 children and youths in two communities, Foster, Qaseem, and Connor, (2004) state, “An important question for future research is whether a public health–oriented strategy of avoiding juvenile justice placements among youths with emotional and behavioral problems is cost-effective. A full economic analysis would depend on how the costs of identifying and treating the mental health problems of a large group of at-risk youths compare with those related to detaining a subset of such individuals in the future” (p. 898).

**Definition incongruity.** Second, assessing offenders with cognitive disabilities is problematical due to semantics and a lack of consensus on definitions (Brier, 1994; Fortune & Lambie, 2004). The tenth version of the International Classification of Diseases (ICD-
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10) (World Health Organization, 2005), lists the criteria for a diagnosis of mental retardation as being “Approximate IQ range of 50 to 69 (in adults, mental age from 9 to under 12 years). Likely to result in some learning difficulties in school. Many adults will be able to work and maintain good social relationships and contribute to society” (¶ 5), but that definition and terminology has not been universally adopted. The fourth version of the Diagnostics and Statistical Manual (DSM-IV) (American Psychiatric Association, 2000) defines the criteria for mental retardation as an IQ of less than 70, impairment on at least two functioning areas, and onset prior to age 18. The American Association of Mental Retardation (2002) defines mental retardation as “a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18” (¶ 2).

In addition to the problem of lack of consensus on definition, researchers have used terms such as learning disabled, mentally retarded, brain damaged, mentally subnormal, developmentally disabled, and mentally handicapped interchangeably throughout the literature, despite the subtle but significant differences that the terms have to various psychological, educational, and medical professionals. For example, Ashman and Duggan (2003) conducted a study on young sexual offenders, and subjects with an IQ under 70 were classified learning disabled, while Charles and McDonald (1997) classified offenders who meet this criterion for mild mental retardation as being developmentally delayed or low-functioning. This problem has been unresolved in the literature for over a quarter of a century. In the late 1970's, an article was published on how teachers should adapt to special needs children being mainstreamed back into the regular classrooms after years of
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segregation. Lovitt (1979) explained, “What should we call the special children who are sent to our classes? ... [These] pupils are returning with labels like mentally retarded and emotionally disturbed and learning disabled. When they left, they were referred to as naughty and slow” (pp. 25-26).

Divergence of methodologies. Lindsay (2002b) reported being unable to draw firm conclusions from research findings on sexual offenders with cognitive disabilities due to the differences in methodologies, including the inclusion criteria, the source of the sample, and the method of determining the intellectual disability. In addition to confusion over terms, the failure of many researchers to report basic demographics and intellectual functioning information about their subjects, such as IQ scores, severely limits the ability of others to retrieve applicable research from databases or to draw conclusions about the findings (Fortune & Lambie, 2004; Lindsay, 2002a). Therefore, to assist sexually abusive youths with cognitive disabilities through the court process and the following intervention services, professionals must have knowledge specific to working with those with disabilities, beginning with acknowledgement of the existence of these youths.

The Center for Sex Offender Management publishes The Glossary of Terms Used in the Management and Treatment of Sexual Offenders (Center for Sex Offender Management, 1999). This publication provides definitions for over 160 terms that professionals can expect to encounter when working with a sexually abusive client. However, the only mention made in the publication of someone with mental disabilities is not in reference to a cognitively challenged offender, but in the need to protect disabled persons from the offender; “[A chaperone] is a person who has been approved by a
supervising officer to supervise contact between a person at risk (generally a minor or developmentally disabled person) and an offender” (p. 5).

Identification of a mental disability is one important aspect of assessment; Hunter (2004) also stressed the importance of specifically identifying youths affected by gestational exposure to alcohol, or Fetal Alcohol Spectrum Disorder (FASD) prior to the start of treatment. He explained that placement of a youth affected by gestational exposure to alcohol into a treatment group with youths of average intellect may undermine the group treatment process and reinforce the negative self image of the affected youth. The youth with FASD may be more likely to blurt out non-sequiturs, have difficulty remaining seated, ask the same questions repeatedly, and become bored or frustrated with discussion of abstract treatment concepts. Further, Hunter (2004) concluded that youths affected by gestational exposure to alcohol involved in sexual offense treatment are rarely pre-identified for data collection as a sub-group, so attempts at determining treatment efficacy with them is not feasible at this time, highlighting the need for further, and more detailed exploration of this population to address the need for specialized education for clinicians and empirically-supported treatment and programming for sexual offenders with disabilities.

Those who do not meet the criteria for mental retardation but have learning disabilities also present challenges in assessment. Many assessment tools rely on a minimum level of literacy in the client, and for those able to complete the testing, being formally identified as having a learning disability can result in being identified as being in need of extra assistance: a designation that can have serious social consequences for the adolescent at school. Fletcher, Francis, Morris and Lyon (2005) addressed this concern, and...
described how early theories saw a youth being identified as having a learning disability if he did not reach achievement levels as expected. Their evaluation of the testing used to identify a learning disability found aptitude-achievement and intra-individual difference models to have little support. They recommended assessments adopt a response to intervention model in conjunction with achievement testing to address reliability and validity issues. Further, they emphasize that youths who have difficulty learning as the result of mental handicap, language barriers, sensory difficulties, or environmental factors should not be identified as being learning disabled. Fletcher et al. take objection to one-time assessments, which identify a youth as learning disabled, stating such assessments are unreliable, and stress that “children should not be diagnosed as learning disabled until a proper attempt at instruction has been made” (Fletcher, et al., 2005, p. 519).

_Treatment for Youths Who Sexually Offend_

In 1993, Lab and Shields stated, “empirical research and evaluation has not accompanied the growth of sexual offender programming” (p. 546). Since then, the growth has been substantial (Bonner, Marx, Thompson, & Michaelson, 1998). Longo (2006) explained that the need for treatment for adolescent sexual offenders began to be addressed seriously in the United States in the 1970s, and has grown exponentially to date. He explained that in 1978, there were 40 treatment centres for adolescent sexual offenders in the United States. That number grew to 346 in 1986, 626 in 1990, and 937 in 2002 (Longo, 2006).

Although programs in Canada are increasing in number, access to qualified clinicians who specialize in the assessment and treatment of youth who commit sexual
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offenses is limited, even in metropolitan areas (National Clearinghouse on Family Violence, 2002). Throughout the northern areas of Canada, treatment programs for youth who are sexually intrusive are scarce, and for those youths with cognitive disabilities who commit sexual offenses, specialized treatment programs are almost non-existent.

_Treatment Program Development_

Due to a prior lack of research in the field, youths who committed sexual offenses prior to the 1980's were often sent to treatment where they were limited to receiving simplified social skills training, or programming originally designed for the adult, non-mentally handicapped offender that had been modified by the individual therapist (Bell, 1994; D. Adams, personal communications, November 22, 2002). Barbaree, Marshall and Hudson (1993) attested that juvenile sexual offenders are not small versions of adult sexual offenders; therefore, their treatment needs are different. Righthand and Welsh (2001) conducted an extensive review of the literature on juveniles who have sexually offended, and they echoed the statement that treatment programs frequently exposed youths to material originally designed for adults. They identified that these programs did not take into account the developmental issues and needs unique to juveniles who have sexually offended. Further, the conveyance of treatment and impartation of information did not appear to be consistent, nor did all models appear to take into consideration the individual needs of the treatment recipients. In agreement, the Center for Sex Offender Management (2002) stated that adolescent sexual offenders are profoundly different from adult sexual offenders and that it is inappropriate to treat adolescent sexual offenders as adults are treated.
Despite the finding that adolescent sexual offenders are different from adult sexual offenders and despite the consensus on the need for programming specific to adolescents, there is a lack of consensus on the best model for treatment of the adolescent sex offender population. Grant (2000) claimed that treatment for adolescents who sexually offend has developed primarily through trial and error due to the lack of consensus. This trial and error approach has been evident not only for individual treatment, but in the development of treatment programs; of 195 treatment programs studied by Latimer et al. (2003) spanning four countries, only 11 of the programs provided specific staff training and supervision, monitored program compliance, and reported having a program manual.

In a major step towards implementing a uniform and empirically based treatment program for British Columbia's adolescents who commit sexual offenses, a provincial committee assembled by Youth Forensic Psychiatric Services (YFPS) researched program delivery for this population. The committee, which consisted of psychologists, psychiatric nurses, and psychiatric social workers, culminated their efforts with production of a set of standards and guidelines for assessing, treating and managing youth who have sexually offended (Youth Forensic Psychiatric Services, 2004).

Treatment Goals

Motivation for treatment is an under-researched subject, but Tierney and McCabe (2002) believe it is a key factor, given the number of treatment programs where the client's motivation is a determining factor in their acceptance into the treatment program. Tierney and McCabe noted that some researchers have found this practice to be disagreeable because it often excludes the most dangerous offenders from treatment, raising the argument that it is the purpose of treatment to motivate the offender to change.
However, numerous researchers have concurred on the goals for treatment of those who sexually offend (Barbaree & Cortoni, 1993; Davis & Leitenberg, 1987; Ertl & McNamara, 1997; Grisso, 2004; Kahn 1997; National Adolescent Perpetrator Network, 1993; Perry & Orchard, 1992; Righthand & Welsh, 2001). These goals can be categorized under the four primary objectives of treatment for those who offend sexually: (i) to reduce the risk of sexual offending, (ii) to improve psychological, social and adaptive functioning, (iii) to treat and control co-morbid conditions where identified, and (iv) to plan, discharge and facilitate integration into the family and/or community (Youth Forensic Psychiatric Services, 2004).

Reducing risk with external controls – reducing risk to potential victims. Early in treatment, control of the client’s environment provides an external means of risk reduction. The judge usually sets the controls through conditions on the client’s probation order. Probation conditions intended to provide external control to reduce risk of reoffense by a youth who has offended against children may include: (i) the youth is to have no contact, nor reside with, the victim, or any child under the age of 14, unless approved in advance and in writing by the supervising probation officer; (ii) the youth shall not go near school yards, parks, arcades, playgrounds, swimming pools, or other places primarily frequented by children under the age of 14 unless approved in advance and in writing by the supervising probation officer; (iii) the youth shall not be employed in or participate in any volunteer activity that involves children or access to them, except under circumstances approved in advance and in writing by the supervising probation officer; (iv) the youth shall abide by any curfew imposed by the supervising probation officer; and (v) the youth shall report to the supervising probation officer when directed, and attend all scheduled
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appointments. Through enforcement of these conditions that restrict the freedoms of the youth who has sexually offended, the risk for reoffense is reduced through decreased opportunities for the client to access potential victims.

Reducing risk with internal controls. A goal of treatment is to instil sufficient internal controls to replace the external controls that are removed from the offender at the expiration of his probation order. Historically, treatment providers have tried various approaches to reduce the likelihood of reoffense, including attempts to educate clients more effectively, beginning when they are incarcerated in the criminal justice system (Roys, 1997), and continuing in outpatient treatment (Borduin, Henggeler, Scott, Blaske & Stein, 1990; Lab & Shields, 1993; Weinrott, Riggan, & Frothingham, 1997).

One of the first steps towards development of internal controls is admission of the offenses, and elimination of denial. Baldwin and Roys' (1998) study confirmed that deniers demonstrate more defensiveness, less cooperation and minimize even everyday problems widely endorsed in the general public. Lord and Wilmot (2004) found three reasons for denial in offenders: low motivation or insight, threats to self-esteem and image, and fear of consequences. They identified helpers for overcoming denial, a critical step for treatment, such as development of a trusting environment with support and direct encouragement, where the benefit of admission outweighs the benefit of continued denial. “As long as the offender denies his offense, he will not be motivated to engage in treatment as a sex offender” (Barbaree & Cortoni, 1993, p. 255). Denial efforts in the client typically pervade not only their descriptions of the offense, but also their acceptance of personal responsibility in other areas of their lives. These offenders often view their environment,
and the people in it, in a distorted manner to alleviate any personal responsibility for actions and harm, and firmly adhere to their distorted beliefs.

Danni and Hampe (2000) identified a common cognitive distortion of those who offend against children: pedophiles believe their relationship with children is intolerably misunderstood, some even believing that the child benefited from their interactions with the offender and were not harmed by the offense. This type of cognitive distortion supports the client's deviant arousal. O'Shaugnessy (2002) explained that most sexual offenders who have deviant arousal will reinforce that deviant arousal through repeated use of a deviant fantasy during masturbation. Therefore, early intervention with adolescents is more likely to correct deviant arousal patterns than treatment with adults after years of self-conditioning behaviour. Although the focus of treatment for this population does vary between treatment providers (Blanchette, 1996; Worling & Curwen, 2000), most identify that addressing the client’s cognitive distortions is important to provide effective treatment (Egan, Kavanagh & Blair, 2005; Hanson & Harris, 2000; Lakey, 1994).

*Improving psychological, social, and adaptive functioning.* Following reduction of denial, increased empathy is a common component of treatment for those who offend sexually. Many researchers claim that empathy development is an important deterrent to reoffending behaviour (Farr et al., 2004; Kahn, 1997; National Adolescent Perpetrator Network, 1993; Ryan, 1999), and is an important step towards improvement of a client’s overall functioning. Ryan et al. (1996) identified treatment for trauma in the histories of youth sexual offenders to be one of the most important focal points for intervention, and added later (Ryan, 1999) that treatment should focus on six goals: awareness of abuse in their daily lives, awareness of their abuse cycle and its related patterns, development of
new coping skills, recognition of the contributing factors for relapse, daily practice of empathic skills, and the skills to develop and maintain healthy relationships.

Other treatment goals intended to improve the client’s psychological, social and adaptive functioning include: creating awareness of physical, sexual and emotional needs; enhancing skills in communication, conflict resolution, social interaction, planning, and problem solving; understanding intimacy and sexuality; resolving the client’s own prior abuse issues; learning appropriate relationship behaviours; reconciling with family; and enhancing self-esteem and insight (Youth Forensic Psychiatric Services, 2004).

_Treatment of comorbid conditions._ Another goal of treatment is addressing comorbid disorders. Research has shown that adolescents who sexually offend have a high rate of comorbid diagnoses (Bourke & Donohue, 1996). For example, Abacan et al. (2004) found that substance abuse was the most significant predictor of membership in a sexual offending subgroup. Other comorbid diagnoses may include “disorders of mood (e.g., Major Depression and Dysthymia), anxiety, attention-deficit/hyperactivity, disruptive behavior (e.g., Conduct Disorder), and substance use” (Grisso, 2004, p. 33). In addition to psychotherapy, clinicians may use pharmacological therapy as required (Freeman-Longo, 1990; Petrunik, 2003; Righthand & Welsh, 2001; Youth Forensic Psychiatric Services, 2004).

_Reintegration into family and community._ Assisting the youth to reintegrate successfully with his family and community is recognized as an important treatment goal (Falls, 2001; Foley, 2001; Gordon & Porporino, 1990; Lane Council of Governments, 2003; Nuffield, 2003; Office of the Auditor General, 2002; Petrunik, 2003; Pithers & Gray, 1998; Youth Forensic Psychiatric Services, 2004), and is one of the principle objectives of
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the Youth Criminal Justice Act (Department of Justice Canada, 2006b; Government of Canada, 2002).

Research demonstrates that family involvement and efforts put into reintegration of the youth are effective. In his meta-analysis on treating youth in conflict with the law, Latimer et al., (2003) examined 195 unique treatment programs and determined that programs that involved family had an effect size of +0.16, compared to the effect size of those with only individual focus at +0.13. However, programs which targeted positive communication in the family showed effect sizes of +0.20, compared to only +0.09 in those programs which did not include family for development of these skills.

Family involvement and community case planning are important components in preparation for the youth’s discharge from the treatment program. At YFPS, discharge planning begins on intake and continues through the program until after the discharge date. Ideally, and with the youth’s written consent, the youth’s caregivers meet regularly with the clinician, participate in integrated case management meetings with involved community support services, and provide feedback to the clinician on the youth’s progress. At YFPS, the clinicians primarily use cognitive-behavioural interventions to meet all of these treatment goals: an approach well supported in the literature (Becker & Kaplan, 1993; Duehn, 1994; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson & Harris, 2000; Robertson, Grimes & Rogers, 2001; Wilcox, 2004). In addition, Henry and Cashwell (1998) have identified that “Reality Therapy is an approach that stresses responsibility, involvement and morality – all proven effective in the treatment of sex offenders” (p. 10).
One of the clearest examples of the use of cognitive behavioural therapy in the treatment of sexual offending behaviour is in the use of sensitization, where deviant sexual fantasies are linked, to negative images of catastrophic consequences, individual to the client. In an attempt to develop a form of aversive conditioning for sexual offenders, Wienrott et al. (1997) conducted an experiment with 69 youths who had committed hands-on sexual offenses. Some of the youths were assigned to a control group, which did not deny access to service, but used youth on a waitlist for service for comparison purposes. The experiment used vicarious sensitization, with visual aids, to test the effect of aversive conditioning with vicarious sensitization. The program exposed the youths to an auditory depiction of their crime scenario, followed by videos of aversive vignettes. The aversive vignettes were prepared in advance with the use of actors and depicted negative consequences resulting from the offender’s actions. For example, a vignette depicted the offender being caught by the victim’s parent, or by their own girlfriend. The youths were exposed to the series of aversive vignettes repeatedly, and were also provided with wallet cards depicting the aversive vignettes to refer to when experiencing deviant urges outside of the clinic. Weinrott et al. discovered, by way of phallometric measurement, that the effects of vicarious sensitization were more effective than covert sensitization and faster than verbal satiation. Further research is required to determine the reliability, and feasibility, of this form of treatment.

Specialized Treatment for the Cognitively Disabled

Ashman and Duggan (2003) noted that because clients may have an identified learning disability, limited reasoning, poor adaptive and verbal skills, poor concentration
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skills, low levels of understanding of abstract concepts, or inappropriate behaviours, treatment programs must compensate for these deficiencies: a philosophy that has grown in popularity during the past two decades (Tudiver, Broekstra, Josselyn, & Barbaree, 2000).

Special education research leads to specialized offender treatment. Early studies in the field of special education for adolescents with learning disabilities focused on assisting teachers of learning-disabled youths in the public school system. Those early studies focused on diagnostic measures with the evolution of research on learning styles taking into account such variables as perceptual differences (Eiszler, 1983), relationships between cognitive development and learning styles (Melone, 1987), cultural differences in learning style (Peeke, Steward & Ruddock, 1998), and the differentiation of abstract, active, reflective and concrete learning styles (Titus, Bergandi, & Shyrock, 1990). While some researchers have identified the importance of early interventions for children at the onset of their education years, others have emphasized the importance of interventions for adolescents. “The need for effective intervention strategies for these older individuals is as great as, if not greater than, the need for interventions for younger children because of all the emotional overlays that generally emerge as individuals mature and continue to encounter significant failure” (Deshler, 2005).

An understanding of the importance of specialized treatment for youth involved in the justice system is coming late. The number of studies on the effects of catering education to learning disabilities has increased markedly (Gardner, Graeber & Machkovitz, 1998; Glick & Sturgeon, 1999; O’Connor, 1996; Stermac & Sheridan, 1993), yet it has only been in the past 20 years that researchers have made the connection between the education of special needs youths in the schools, and the need for specialized treatment for
learning-disabled offenders (Curtis, 1984; Mann, 2004; Petersilia, 2000; Rice & Harris, 1997). It was as recently as 1999 that researchers bridged the gap to corrections-based services when they began exploration in the specialized field of education for incarcerated youths with cognitive disabilities (Robinson & Rapport, 1999).

Becker (1993) critically reviewed the empirical literature relevant to the adolescent sex offender and determined out of 73 articles, forty-three related to the characteristics of juvenile sex offenders, twenty-three discussed treatment issues, and the remaining seven focused on miscellaneous issues. None dealt specifically with the provision of treatment for learning-disabled youth who commit sexual offenses.

Duehn (1994) emphasized that treatment for this special population needed to be adjusted to be understood by the cognitively disabled client, and Brier (1994) stated the treatment also needed to be skills oriented and needs based. That same year, one of the most often cited studies on sexual offenses committed by persons with cognitive disabilities was released. In his study of 47 adult males, Day (1994) reiterated that the literature had neglected mentally handicapped sex offenders and he identified the need for more comparison studies to determine if his findings were consistent in the population. His study determined that differences existed between offenses of cognitively disabled and non-disabled sexual offenders:

Mentally handicapped sex offenders [were found to be] more likely than non-handicapped sex offenders to commit offenses against both males and females, against both same-age and older victims, and are less likely to know their victims, to commit violence, or to commit penile penetration of the vagina (p. 630).

Ashman and Duggan (2003) identified that because clients may have an identified learning disability, limited reasoning, poor adaptive and verbal skills, poor concentration
skills, low levels of understanding of abstract concepts, or inappropriate behaviours, treatment programs must compensate for these deficiencies. That same year, Bruxholme and Lindsay (2003) attempted to create a reliable self-report questionnaire to assess cognitive distortions in intellectually disabled sexual offenders, the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO). In hindsight, they noted that they did not collect sufficient comprehensive background information on each participant, so factors such as psychiatric conditions, prior exposure to sex offender treatment or education, and the offender’s own view of their behaviour were not taken into consideration. However, their development of the tool was a positive indication that researchers were making an effort to understand better this special population: an important step towards more effective treatment.

At Youth Forensic Psychiatric Services, clinicians have assigned adolescents with cognitive and social deficits to special treatment programs: clinician-modified programming, adapted from the mainstream program. This has been problematic in several ways. First, due to lack of consensus from empirically defined criteria for identification of a special needs adolescent sexual offender, this assignment is based primarily on clinician decision. Clinicians support the decision with experience and with information gathered during assessment of the youth prior to treatment interventions. This information includes psychometric testing results and analysis of data collected from collateral sources, such as birth records, school files and physician records. However, the specific factors used in making the decision have not been recorded collectively across the province, making comparisons between YFPS groups difficult to accomplish.
Second, the modified programming provided at the various clinics has been assembled based on available materials, clinician experience, and perceived client needs, again, due to a lack of empirical evidence on efficacy of treatment components to guide practice (Eastman, 2004). Without consistent components in use and without inter­presenter reliability, ascertaining treatment component efficacy remains a challenge. The first step toward an empirically based program required a closer look at the youth selected to receive modified programming. A study of YFPS clients (Regan et al., in press) reviewed extensive file information for youth referred to the Youth Forensic Psychiatric Services’ Burnaby clinic for sexual offense treatment between October 1990 and June 1999. They analysed background, personality and cognitive functioning data and discovered that those assigned to the special needs group had a mean intelligence quotient fifteen points lower than that of the non-special needs group. Their data revealed also that 22.4% of the non-special needs group had diagnoses of a learning disability, compared to 63.3% in those youth assigned to the special needs group. Further, the non-special needs group involved no youths with an FAS/FAE diagnosis, compared to 13.3% with that diagnosis in the special needs treatment program.

In addition to the question of how best to identify those requiring special programming is the question of what that programming should entail. As with non-disabled adolescent offenders, these youth benefit from learning appropriate social and communication skills (Tudiver et al., 2000). Youths with cognitive disabilities and a history of anger problems can benefit from a structured treatment program that explores negative experiences to aid in preparation for future encounters (Taylor, Novaco, Gillmer
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Tudiver et al. outlined the obstacles to be considered when providing treatment to this special population:

“treatment programs should recognize and address the particular obstacles in attaining the treatment goals that face an offender with developmental delay, such as: lack of opportunity to learn appropriate sexual behaviour through experimentation and trial-and-error at an early age; high probability of having been sexually victimized; social isolation; poor community acceptance of healthy sexual behaviour; lack of opportunities for age-appropriate sexuality; and difficulty learning complex social rules and norms relating to dating, intimacy, and sex” (p. 20).

Post-Treatment Evaluations

Although the significant aspects necessary for accurate prediction with this population have yet to be proven (Lindsay, Elliot & Astell, 2004), “the courts frequently task clinicians with the responsibility of helping determine the risk that clients represent for future sexual offending” (Hunter & Lexier, 1998, p. 344). Indeed, when referring a youth for a pre-disposition assessment, the courts often ask the assessment team at Youth Forensic Psychiatric Services to address the level of risk that the youth poses to the community. Similarly, at the end of treatment, probation officers, and more frequently the youths’ families, want to know if the treatment was successful. All are asking the same question, “What are the chances that this youth will reoffend?” In an attempt to answer this question accurately, researchers have given treatment efficacy and assessment of reoffense risk considerable attention.

Treatment Efficacy

Gottschalk, Davidson, Genscheimer, and Mayer (1987) conducted a meta-analysis on the literature relating to community-based interventions with adolescent offenders. They
reviewed 90 studies involving over 11,000 youths and found that interventions in community settings did not have a large influence. In explanation of the findings, the authors hypothesized that their findings may have been impacted by including studies regardless of quality. They also identified how the lack of information on both subject characteristics and content of intervention components interfered with the formation of conclusive results (Gottschalk et al., 1987).

An important factor to consider in evaluating the findings of the study is that the Gottschalk et al. (1987) analysis focused on studies published between 1967 and 1983: a time when the field of treatment for adolescent sexual offenders was new and research had not identified the need for adult treatment to be adapted for youths. However, in a meta analysis of 200 studies, Lipsey and Wilson (1998) concluded that treatment did have an effect. They found that there were larger effect sizes for the more serious offenders, treatment delivery problems correlated with lower effect size, the duration of treatment was positively associated with effect, and interestingly, the mean treatment hours per week was negatively correlated with effect, suggesting a benefit in longer programs rather than programs based on short-term intensity.

Hanson, Gordon, Harris, Marques, Murphy, Quinsey, et al. (2002) identified the influence of program development over time in their more recent meta-analytic review on the effectiveness of treatment for sex offenders. Hanson et al. examined data from 43 studies, representing 5078 treated and 4376 untreated clients and, noting that offenders who received treatment had consistently lower recidivism rates than the comparison groups, concluded that forms of treatment used prior to 1980 appeared to have little effect. Last year, Hanson and Morton-Bourgon (2005) conducted a meta-analysis comparing
They found sexual recidivism levels to be lower than the violent nonsexual recidivism levels, and the general recidivism rate to be highest at 36.2%. In a recidivism study with a 10 year follow up, Waite, Keller, McGarvey, Wieckowski, Pinkerton, and Brown (2005) stated,

“This study offers two important findings: rates of recidivism, based on re-arrests, for sexual offences among juvenile sex offenders are very low, regardless of the intensity of treatment during incarceration, and high impulsive/antisocial behaviors significantly increase the probability of recidivism, again regardless of type of treatment during incarceration. The actual re-arrest rate for sexual offences for the entire sample of incarcerated adolescent sex offenders was only 4.7% with an average at risk time over 5 years (61.9 months).”

Grossman, Martis, and Fichtner, (1999) stated, “Research supports the view that treatment can decrease sex offense and protect potential victims” (p. 349), a statement also supported more recently by Reitzel (2005), who found treatment for juvenile sexual offenders resulted in a significant effect size. However, conclusive findings on the effecting variables remain undetermined; researchers have conducted a variety of studies in an attempt to find correlations between recidivism rates and specific individual variables. Kahn and Chambers (1991) identified eight classes of variables with this population: demographics, abuse history and family variables, sexual offense characteristics, justice system response, response to treatment, location and type of treatment, reason for termination, and finally, number and types of previous convictions.

In an attempt to determine risk to reoffend, researchers have focused on these classes of variables and have looked specifically at community or institution based treatment (Kahn & Chambers, 1991; Looman, Abracen & Nicholaichuk, 2000); good treatment behaviour (Seto & Barbaree, 1999); social, sexual and family functioning...
Youth who sexually offend 90 (Launay, 2001; Worling & Curwen, 2000); social skills level (Graves, Openshaw & Adams, 1992); conduct disorder, previous criminal convictions and psychopathy (Langstrom et al., 2000); impulse control (Krauss, Sales, Becker, & Figueredo, 2000), and treatment completion (Brier 1994; Maletzky & Steinhauser, 2002).

In a study of the effects of treatment locations, Lipsey and Wilson, 1998 discovered that in outpatient interventions, effects were more strongly related to the client characteristics, especially prior offense history. Treatment type and duration was intermediate, and program characteristics showed a fallible correlation. For inpatient interventions, the opposite was true: program characteristics were associated with the largest effect size, type of program and duration was intermediate, and the characteristics of the clients had little influence on the effect size. Lipsey and Wilson acknowledged the need for further research to clarify efficacy of specific treatment interventions, and stated that treatment success depends on the correct match of program delivery site and clientele. They also emphasised that the serious offenders were more helped by intervention than the rest, contrary to popular belief that repeat offenders are the least likely to benefit from treatment.

Lindsay and Smith (1998) had similar findings in their study of 14 adult male sex offenders with cognitive disabilities. Seven were serving one-year probation terms and seven more serious offenders were serving two-year probation terms, with the follow up measure taking place two years after probation completion. Their study revealed a significant difference in treatment effect between the two groups, both of which improved with intervention, with the greatest results seen in the group who had served the longer probation period.
Also in 1994, Brier studied 192 youths, aged 16 to 21. Of those, 73 completed treatment, 85 did not, and 34 were untreated. All had less than two prior arrests and none had histories of violent crimes, mental illness, or substance problems. Brier found that subjects who had completed the program had a significantly lower recidivism rate, relative to both those that did not complete and to subjects in a matched group. Of note, the participants that completed the program had been provided with a significant motivator: participation in the program was rewarded with deferred prosecution. Maltezky and Steinhauser's (2002) study of over 7000 offenders found that cognitive-behavioural programs reduced recidivism and risk to the community, situational offenders showed fewer reoffenses than the rapists and homosexual pedophiles, and rapists had the highest reoffense rate. They also noted that failure rates increased with the length of time since treatment completion, and not completing treatment was found to be a strong indicator of risk to reoffend.

Marshall and Barbaree (1990b) studied outcomes from four treatment clinics, including 3163 subjects, and found the recidivism rates for untreated offenders were high: those who offended non-familial victims had a recidivism rate of 43%, the rate for incestual offenders was 22%, and 67% for exhibitionists. It is important to note that their subjects were untreated primarily due to the client's refusal to accept treatment: possibly indicating an attitudinal factor in the findings. These findings contrasted with those of Hanson (2001), who completed a large study of 4763 subjects and determined that deviant sexual interests, low self-control, and opportunity were consistent factors for sexual offending for rapists as well as extrafamilial child sexual offenders. In his study, incestual offenders between the ages of 18 and 24 had the highest recidivism rate of all the
categories, at over 30%, identifying, he says, the need for specific research on this group to
determine if incestual offenders are a distinct type.

The study of 7275 sexual offenders with a 25-year follow-up by Maletzky and
Steinhauser (2002) determined that cognitive-behavioural programs reduced recidivism and
risk to the community. They concluded that situational offenders showed fewer reoffenses
than the rapists and homosexual pedophiles, and claimed rapists had the highest reoffense
rate. Failure rates increased with the length of time since treatment completion, and failing
to complete treatment was found to be a strong indicator of risk for reoffending. Similarly,
a German study (Stadtland, Hollweg, Kleindienst, Dietl, Reich, & Nedopil, 2005) found
that only one member of a group of non-completers had not reoffended during the follow-
up period.

Age of onset of criminal behaviour also appears to be an influencing factor in the
likelihood of reoffense, according to the outcome of a study by Jones, Harris, Fader, and
Grubstien (2001). They determined that there was a distinct difference in reoffense risk
between offenders who commit crimes before age 15 (high risk) and those who started their
criminal careers after the age of 15 (lower risk). They also concluded that positive peer-
culture programs have relatively little effect on high-risk, early delinquents, indicating the
need for specialized intervention.

One of the most frequently cited controlled-treatment outcome studies was on the
effectiveness of multi-systemic therapy (MST), a study conducted by Borduin et al.,
(1990). MST focuses on empowering the client's support network and involving them in
the therapy process to bring about change in the client (Swenson, Henggeler, &
Schoenwald, 1998). Youths in the Borduin et al. study were randomly assigned to one of
two treatment modalities, MST or individual therapy (IT), and MST was determined to be quite successful. As Langstrom (2001) points out, the study by Borduin et al (1990) is severely limited due to the small sample size and the short study term: only eight youths were assigned to each group before three from each group dropped out, and the follow-up time was a relatively short three years. “In addition, although MST is based on social ecological theory and is thus designed to address the various characteristics that directly and indirectly maintain the sexually abusive behaviors, none of these characteristics was included in the assessment of treatment effectiveness” (Brown & Kolko, 1998, p367).

In response, five years later Borduin, Mann, Cone, Henggeler, Fucci, Blaske, and Williams (1995) released a study of families of adolescent offenders who were randomly assigned to, and completed, either MST (n=92) or individual treatment (n=84), with an average follow-up of 3.95 years. Those youths that completed the MST program had a lower re-arrest rate ($M=1.57, SD=0.85$) than those that completed the individual therapy ($M=4.41, SD=3.89$).

Psychopathy was another variable examined in studies of risk with this population. In a review by Seto and Barbaree (1999) rated 283 clients on the revised Psychopathy checklist (Hare 1990), and then collected information on the clients’ success based on the National Parole Board’s records. They found that clients who performed well in treatment but had higher psychopathy scores were almost three times as likely to commit another criminal offense, and more than five times as likely to commit a serious offense (Seto & Barbaree, 1999). Similarly, Gretton, McBride, Hare, O’Shaughnessy and Kumka’s (2001) examination of the psychopathy scores for 220 adolescent sexual offenders found those with high scores were “more likely than other adolescent offenders to escape from custody,
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violate the conditions of probation, and commit non-violent and violent offenses in the 5-year follow-up period” (p.444).

These findings raise the concern that sexual offenders with higher psychopathy scores who gain social skills in treatment without accepting responsibility or gaining insight into their behaviour might be aided in reoffending through the acquisition of their new social skills. However, Barbaree (2005) pointed out in his follow-up study that the statistics in his 1999 report were weak because they failed to take into consideration time-at-risk when performing the comparisons of recidivism rates.

Hanson and Bussiere (1998) reviewed 61 studies and concluded that recidivism was best predicted by the offender’s level of sexual deviancy and general criminological factors. They observed the sexual recidivism rate is typically 10% to 15% five years post-intervention, while Kelley et al. (2004) report the recidivism base rate for untreated sex offenders is higher, at 15-35%. A study specific to reoffending by British Columbia’s youths, questioned the recidivism rate for 116 youth offenders, four years after intervention (Hemphill, 2004). The data showed the sexual reoffense rate was a relatively low 6%.

Although research indicates that intervention can reduce the likelihood of reoffending, until we can accurately identify who needs intervention, the causes of the problem behaviour, and what specific interventions are valid and appropriate, we cannot make accurate conclusions about treatment efficacy (Lab and Shields, 1993).

Latimer et al., (2003) completed a meta-analysis on the treatment of young offenders and generated 15 recommendations linked to a reduction in reoffending:

1. conduct the treatment in a therapeutic environment using multiple forms of counselling (individual, group and family);

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6 Permission to quote granted. See Appendix 5.
2. screen youth for anger issues and provide an anger management component where suitable;
3. directly involve educators within the treatment program and directly target school performance and attendance where necessary;
4. target anti-social attitudes in treatment including encouraging respect for authority and for the institutions of the criminal justice system;
5. develop cognitive skills in the youth in order to improve problem solving, perspective taking and goal setting;
6. enhance social skills including communication strategies and the ability to work within groups (e.g., giving and receiving feedback);
7. encourage and teach positive communication (e.g., warm, respectful, honest) within families;
8. provided parents with the appropriate skills to monitor and supervise youth;
9. increase the employment potential of the youth (where maturity and external obligations permit) by offering specific vocational training and provide general skills such as resume writing and interviewing for acquiring and maintaining gainful employment;
10. limit the program length to six months and provide a maximum of 20 hours of program exposure for low risk offenders and increase the treatment dosage for high risk offenders;
11. develop program manuals, provide staff training and supervision, and measure program compliance;
12. attempt to provide suitable interventions early in the lives of youth in conflict with the law;
13. encourage meaningful and substantial family involvement in the program;
14. attempt to involve the community (e.g., police, non-governmental organizations, community leaders) within the treatment program where appropriate; and,
15. address ambiguous and less promising treatment targets (anti-social peers, relapse prevention, community functioning, substance abuse, psychological well-being, leisure/recreation) and other non-criminogenic needs when deemed appropriate on a case by case basis” (Latimer et al., 2003, pp 20-21).

Validity of Recidivism Rates

Many studies that evaluate efficacy of treatment or risk of reoffense, such as that of Latimer et al., (2003) provide the rate of recidivism as measure of the effect of the intervention. Although researchers have yet to determine a more effective means of accurately tracking post-treatment subjects in the justice system, there are some limitations with the use of recidivism rates to indicate intervention efficacy. For example, there is a
lack of concurrence on the use of the term *recidivism*, specifically with studies addressing those who sexually offend and the definition of recidivism is at the root of the issue.

Recidivism is defined as “a tendency to relapse into a previous condition or mode of behavior; *especially:* relapse into criminal behavior” (Merriam Webster, 2006). Some researchers use the term recidivism rate to refer to the number of re-arrests for sexual offenses, while others use the term to refer to the total number of re-arrests for *all* types of offenses. Clearly, there are significant differences between these two definitions of the term.

Interventions with sexual offenders are aimed primarily at reducing the risk of a sexual reoffense. Studies that report on general recidivism rates, without details on the types of offenses committed after intervention, reduce the reader’s ability to generalize the findings or to compare the findings to other studies that focus specifically on sexual reoffenses. Courtney and Rose (2004) recognized this inconsistency in studies of those with cognitive disabilities as well, and stated, “cooperation between research groups and agreement of standards would increase the quality of research” (p. 233).

Another issue with the use of recidivism as a measure of efficacy is that recidivism figures represent reported reoffenses; research has repeatedly shown that many offenses are not reported, or are not reported until the child victim has reached adulthood (Blackburn, 1993; Christodoulides, et al., 2005; Freeman-Longo, 1990; Statistics Canada, 2003a; Woods, 1997). Therefore, it is highly probable that the reported recidivism rates underrepresent the actual number of sexual offenses committed by those who completed treatment. Further, unless an efficacy study specifically examines all types of re-offense, such as property offenses, the treatment efficacy results may be misleading.


*Treatment Efficacy with the Cognitively Disabled*

While many researchers bemoan the lack of empirical literature on adolescent sexual offenders, the number of studies on juvenile sexual offenders has grown significantly in recent years. Smith, Craig, Loose, Brodus, & Kimmelman (2002) amassed a bibliography of 531 entries on the topic of juvenile sex offenders. The rate of growth in the study of this population was evident by examination of the dates of publication of the entries they listed; only 14 entries represented studies conducted in the three decades of the 1950's, 1960's, and 1970's, while 118 entries represented studies conducted during the three year period of 2000 to 2003. Yet, there is a paucity of information specific to adolescent sexual offenders with cognitive disabilities.

Ashman and Duggan (2003) examined specific criteria in their electronic searches and could not identify any randomized controlled trials on the evidence of effectiveness of treatment for sexual offenders with learning disabilities. They noted that clinicians are still unable to base their choice of intervention for treatment of this subgroup on randomized controlled trial evidence. As with other facets in the treatment of sexual offending behaviour, studies on adult sexual offenders with cognitive disabilities have guided clinicians working with this special sub-group of adolescent offenders. Similarly, efficacy studies with the adult population have provided us with some guidance, and have laid the groundwork for studies specific to the efficacy of interventions with cognitively challenged youths with sexually intrusive behaviours.

Lindsay et al. (2004) conducted a study on 106 adult sexual offenders with an average IQ of 64.3 and 78 general offenders with an average IQ of 65.4. They found, as would be expected, that treatment targeted at intellectually disabled clients showed lower
recidivism rates than general programs attended by intellectually disabled clients.

However, unlike Glaser and Deane (1999), this study found that sexual offenders had committed more prior sexual offenses than the comparison group, and the sexual offenders reoffended less than non-sexual offenders. Later, Lindsay et al. (2004) conducted a study of 52 adult sexual offenders (age range 56-75 years) with mild to moderate intellectual disabilities (average IQ was 64.3), and determined those factors which have repeatedly been identified in the literature as being predictive of reoffense; that is, poor response to treatment, denial, low self-esteem, and lack of assertiveness, also emerged in this study as robust dynamic risk factors related to recidivism.

Addressing another consideration regarding recidivism of youths with cognitive disabilities, Hunter (2004) reported that youth with Fetal Alcohol Spectrum Disorders who are involved in sexual offense treatment are rarely pre-identified for data collection as a sub group, so attempts at determining treatment efficacy with them is not feasible at this time. Courtney and Rose (2004) reviewed the literature on the effectiveness of treatment for male sexual offenders with learning disabilities and found that changing their attitudes towards offending seems possible, and the longer the treatment the longer the change in attitude with less recidivism. However, Courtney and Rose were unable to determine which interventions were successful and which were not. They also noted that many studies did not identify comorbid diagnoses in the subjects.

Campbell (1998) studied influencing factors in treatment and found that the development of self-empowerment and self-determination were key contributors to the participants' success. Wilcox (2004) reviewed the literature on treatment for sexual offenders with intellectual disabilities and determined that there has yet to be any empirical
research which conclusively proves that general cognitive behavioural treatment is beneficial for this population, and research on this topic is difficult due to the lack of both standardized programming and psychometric testing normed to this population. Wilcox concluded that approaches to treatment must be modified for this population and that, as with the mainstream programming, victim empathy must be an integral part of the treatment provided.

Assessing Risk to Reoffend

Although studies are beginning to offer insight into factors related to recidivism of the population, a challenge still faced by assessors of these youth is the question of how to respond to the court’s request to speak to reoffense risk of an individual client. In assessing reoffense risk, the clinician has multiple factors to consider and uses clinical or actuarial means, or a combination of the two, to collect the information needed to make a prediction of the client’s behaviour.

Clinical assessment and actuarial measures. Actuarial measures tend to rely on static factors, while clinical assessment examines the dynamic factors of the individual client. In an attempt to develop an accurate means of assessing risk to reoffend, researchers have studied static and dynamic factors. Commonly identified static predictors include prior criminality, prior sexual offenses, psychopathy, paraphilias and deviant sexual interests, age at time of offense, time spent in custody, victim age and type, poor social skills (Craig, Browne, Stringer, & Beech, 2005). However, Craig et al. note that there is less agreement on dynamic risk factors, which they identified to be deviant sexual urges, low self-esteem, anger, substance abuse, impulsivity, cognitive distortions, lack of victim empathy,
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isolation, unemployment, chaotic lifestyle, poor social support, personality or affective disorders and frequent sexual fantasies.

Bonta (as cited in Gentry, Dulmus, & Theriot, 2005) described the evolution of risk assessment in terms of generations: Generation 1 consisted of clinical judgement based on unstructured interviews; Generation 2 emphasized static risk factors; Generation 3 saw the incorporation of dynamic risk factors. In 2006, Bonta (as cited in Andrews, Bonta, & Wormith, 2006) added Generation 4, which considers factors from intake to discharge, including initial assessments, clinical assessments, and actuarial measures. Some contend that the clinical model is too subjective and therefore unreliable, and others maintain that the actuarial measures “antihumanistic and mechanistic” (Gendreau, Goggin, & Paparozzi, 1996, ¶8).

Neisser (1976) explained that to predict behaviour with any accuracy, the clinician must understand the relationship between perception and behaviour: that is, how both the client’s schemata and his intentions interact with the environment of the situation. Hanson and Bussiere’s (1998) meta-analysis summarized the findings concerning risk factors for reoffense by sexual offenders, and based on static risk factors, they determined that sexual recidivism was not directly linked to the seriousness of the index offense.

A meta-analysis showed that “indicators of class and psychological disturbance were among the least important predictors of general and violent recidivism. In contrast, the best predictors were those associated with an established pattern of prior criminal behavior” (Bonta, Law & Hanson, 1998, p. 139). According to Bonta (in Andrews et al., 2006) the four most significant factors for predicting recidivism are criminal history, antisocial personality, antisocial attitudes, and social support for crime. Relying heavily on
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actuarial measures, Bonta (2002) listed ten guidelines to assist clinicians in assessing risk: (i) assessment of offender risk should be based on actuarial measures of risk; (ii) risk assessments should demonstrate predictive validity; (iii) clinicians should use instruments that are directly relevant to criminal behaviour; (iv) clinicians should select instruments derived from relevant theory; (v) include comprehensive, multi-domain sampling of the factors associated with criminal conduct; (vi) assess criminogenic need factors (vii) limit general personality and cognitive tests to the assessment of responsivity; (viii) use different methods to assess risk and needs; (ix) exercise professional responsibility; and (x) use the assessment tools to determine the most appropriate and least intrusive interventions.

There are several actuarial measurement tools available to assist clinicians in assessing risk. Quinsey, Harris, Rice, and Cormier (1998) developed the Violence Risk Appraisal Guide, one of the first actuarial assessment tools in the field (Lindsay et al., 2004). Although it cannot be used to predict recidivism due to the lack of dynamic factors (Gentry et al., 2005), one of the more popular risk predictors currently in use is the Static-99. The Static-99 includes 10 scales designed to estimate the probability of sexual and violent recidivism with adult males already convicted of at least one sexual offense, and has been found to be a reliable prediction tool (Stadtland et al., 2005).

Bonta (2002) expressed concern that the risk assessment tools most frequently used in the field were not those tools proven the most empirically sound, and recommended more use of the Psychopathy Checklist–Revised (PCL-R) (Hare, 1990), the Violence Risk Appraisal Guide (VRAG) (Harris, G.T., Rice & Quinsey, 1993), and the Level of Service Inventory–Revised (LSI-R) (Andrews & Bonta, 1998). The LSI-R, as described by Abracen and Looman (2005), “describes the understanding and treatment of criminal
behaviour in terms of risk, needs and responsivity principles… [and is] one of the most significant theoretical advances in the area of criminal behavior” (p. 13). Although the LSI-R has not been standardized for use with children under the age of 16 years, Nee and Ellis (2005) used the LSI-R to measure criminogenic risks on regular intervals during intervention to assess treatment progress with youths, and claimed the results gave evidence to the success of their program in reducing reoffense risk. However, their study did not include a follow-up study of the subjects; neither the long-term effects of the intervention nor the accuracy of the LSI-R with this age group could be ascertained.

Although actuarial risk measurement tools have been found to be more accurate than clinical predictors are (Andrews et al., 2006), Andrews et al. emphasized the need for understanding dynamic risk factors when assessing risk to reoffend. Craig et al. (2005) emphasized the importance of developing an actuarial measure that takes into account valid dynamic factors to address changes in the client. One example that includes both static and dynamic factors and is specific for young sexual offenders is the revised Juvenile Sex Offender Assessment Protocol (J-SOAP-II).

Two of the J-SOAP-II scales assess static domains, and two assess dynamic factors that could indicate change in the client, that is, clinical/treatment and community adjustment. In a comparison study with the Youth Level of Service Inventory and Case Management Inventory (Prentky & Righthand, 2003), the J-SOAP II scores showed high correlation ($r=.91$) with further research into the validity and reliability of the J-SOAP-II (Righthand, Prentky, Knight, Carpenter, Hecker, & Nangle, 2005) showing promising results. Another example is the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) (Worling & Curwen, 2001). The ERASOR also assesses dynamic and static
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factors; it includes 25 items designed to assess risk for sexual recidivism in youths between 12 and 18 years old.

Seto (2005) acknowledges that many assessors use several actuarial tools in their assessments of risk despite little empirical data that such practice is effective. Questioning the advantage of combining actuarial measures, Seto determined that there was no statistical benefit to combining scales and concluded that more was not better in terms of increasing prediction accuracy by using multiple actuarial tools. Further, most actuarial measures have not been normed for use with intellectually disabled individuals (Wilcox, 2004), and no one has yet developed a reliable actuarial measure for use specifically with this offender sub-group (Boer et al., 2004; Harris & Tough, 2004). Terry and Ashcroft (2004) found that clients with learning disabilities “cannot cope with long instruments or long interviews. They are also suggestible and inconsistent in their self-report. Their memories can be unreliable. Test-retest of any tool is likely to be poor” (p. 31).

Pointing to the lack of empirical data identifying risk predictors for intellectually disabled persons, Harris and Tough (2004) stated, “Until someone demonstrates that risk for sexual reoffense is different in the intellectually disabled population it is reasonable to apply measures that are used in general, non-intellectually disabled population” (p. 238). In the opinion of this writer, that logic is unsound; although the desire to have tools for use with this population is understandable, the assumption that it is reasonable to use existing tools simply because they have not been proven faulty is equivalent to the assumption that it is acceptable to hammer nails with a wrench. While both approaches may accomplish the goal to varying degrees, neither tool was specifically designed for effective use in that fashion.
Clinician Considerations

Clinicians assessing and treating youth who sexually offend are weighted with a heavy responsibility; their recommendations can influence decisions that affect the safety of a community in respect to the freedoms given to high-risk youths, and their interventions can cause serious, life-altering changes to the youth and his family (Prentky & Righthand, 2003).

Knowledge and Skills

Cashwell and Caruso (1997) maintained that sexual offense treatment providers must have a solid understanding of the issues and possess the necessary skills to work with adolescents, because youth commit 34% to 60% of all sexual offenses. Perry and Orchard (1992) expanded on the general clinical skills required, as identified by the National Task Force on Sexual Offending (National Adolescent Perpetrator’s Network, 1993), and generated a list of skills necessary for working with adolescent sexual offenders. The general skills required include listening, empathy, confronting, supporting, setting firm limits, and the ability to hold clients accountable without damaging the therapeutic relationship. In addition, clinicians need to understand the principles of education; common sense dictates that successful treatment depends on the ability of the clinician to present treatment material in a format comprehensible and acceptable by the youth. Therefore, an understanding of learning styles, teaching techniques, and measurable outcomes are essential.

Clinicians working with youth who sexually offend also need effective confrontation skills. In reference to a 1998 study by Ryan, Henry and Cashwell (1998)
noted, “the level of confrontation must bring the offender to a point of personal discomfort sufficient to facilitate a change in behavior” (p. 10). Clinicians responsible for treating or assessing a youth who has sexually offended are also responsible for presenting their conclusions in a report that may alter the client’s life course, access to services, and personal development. They must also have experience in court work; training and experience in both personal counselling and group therapy; awareness of the various theories for working with youth; and be open to continuation of education, training, and experience, (Perry & Orchard, 1992). Therefore, it is essential that clinicians working with this population possess a combination of education, experience, skill, attitude, and report-writing ability.

Clinicians in this field also need a solid understanding of development across the lifespan, including how adolescent sexual offenders differ from other delinquents. According to Cashwell and Caruso (1997), the inability of clinicians to recognize children and youth as sexual beings is a significant barrier to effective service with this population. Evaluation and treatment of those with sexually abusive behaviours requires a thorough understanding of all the influencing factors (Bernet & Dulcan, 1999), particularly when assessing adolescents. “There are several things about adolescent development that make youths ‘moving targets’ when it comes to identifying their mental disorders and their implications....especially the matter of discontinuity of disorders in adolescence” (Grisso, 2004, p. 64). Therefore, clinicians must be aware of the limitations of assessment and the factors influencing diagnoses and conclusions.

An illustration of this is the extensive longitudinal study conducted with 4000 youths from three major cities in the United States (Huizinga, Loeber, Thornberry, &
Cothem, 2000). The data released in 2000 showed the results of interviews conducted annually over a three-year period. Each year, there were marked differences in the percentage of youths involved in serious delinquency, substance abuse, and externalized behaviour problems. The findings reiterate Grisso’s (2004) warning that the disorder evident on the day of assessment may not be present in the near future, and “with adolescents, one should not presume the current validity of a diagnosis when made more than a few months earlier, or that last year’s diagnosis necessarily explains a youth’s current clinical episode” (p. 66).

Cultural Sensitivity

Clinicians in British Columbia also need to be culturally sensitive. Northern British Columbia consists of a variety of cultures and ethnic backgrounds, particularly people of First Nations’ ancestry. As is the case for clinicians assessing and treating those with cognitive disabilities, clinicians working with youths of First Nations’ ancestry have limited empirical data to guide their interventions with this population, and few actuarial measures have been normed to First Nation culture.

This is significant for clinicians in the northern region where over 15% of the population consists of First Nations people residing on reserves, and an additional estimated 73% of First Nations people residing off reserve (Statistics Canada 2001a; 2001b). Further, there are over 70 native bands in Northern British Columbia (Public Works and Government Services Canada, 2002), representing people of the Secwepemc, Nlaka’pamux, Stl’atl’imc, Coast Salish, Kwakwaka’wakw, Oweekeno, Tsilhqot’in, Nuzalk, Heiltsuk, Haisla, Tsimshian, Wet’suwet’en, Dakelh, Sekani, Gitxsan, Nisga’a,
Adaptability

There is a paucity of training opportunities in British Columbia specific to the assessment and treatment of sexual offenders. As well, there is a lack of readily available materials to use with this population, particularly with cognitively disabled youths who offend sexually. As stated previously, many treatment programs for adults have been used with adolescents, but the literature has shown that these programs are not always well suited for youths. For this reason, clinicians providing treatment to this population often must be creative in their ability to alter and present available materials in ways that will maintain the interest of the youths (Becker & Kaplan, 1993).

Clinicians working in northern British Columbia need to be creative in finding ways to work collaboratively with other professionals based elsewhere in the province, as well. Telephone conferencing and long distance planning meetings are the norm, rather than the exception, when participating in integrated case management meetings or developing community reintegration plans with other agencies. The ability to maintain long distance teamwork is also beneficial in working with fellow YFPS professionals, particularly due to distant specialists.

Limited access to specialists. YFPS clinics in the metropolitan areas typically have a psychologist and a psychiatrist readily available to provide psychiatric assessment and consults for the majority of their clients. Haag (2006) points out that many psychologists have not been specifically trained for work in forensic psychology settings, and do not have
the experience of supervision in a correctional setting. Such is the case in the northern area of the province, where, despite regular national advertisements of the available positions, there remains limited access to specialists; qualified psychologists and psychiatrists are not easily accessible for clients seen at the Prince George outpatient clinic.

The Prince George YFPS clinic contracts to one child psychiatrist in the community, for monitoring of clients’ medications and clinician consults. Due to the lack of sufficient child psychiatrists in the community, that psychiatrist currently provides service to YFPS, the youth custody centre, the child and youth mental health centres, and the adolescent psychiatric unit at the Prince George Hospital; she does not have sufficient time available to take on the role of doing assessments, reports and court presentation. For those tasks, a psychiatrist, employed full time in the Vancouver area, travels to Prince George once a month specifically for assessment purposes. Similarly, due to the lack of psychologists specializing in assessment of this population, YFPS regularly imports two psychologists from southwest British Columbia, each of whom works in the Prince George clinic for three days per month to provide assessment services.

**Geographical considerations.** Those who provide assessment and treatment services to adolescents involved in the justice system also require a thorough understanding of the implications of rural practice, especially when working in the northern region of the province. Gumpert and Saltman (1998) examined rural practice, and identified several issues unique to rural clinicians: cultural factors, such as suspicion of outsiders and confidentiality concerns; resource problems, including lack of transportation; and lack of skilled workers. In addition, they identified two of the axiomatic factors that commonly impede access to treatment: geography and weather. The outpatient clinic located in Prince...
George provides service to northern British Columbia. This vast area, with borders from Haida Gwaii on the West coast across to the Alberta border on the East, and from 100 Mile House in the South to the Yukon Border in the North, consists of over half of the landmass of the province: approximately 400,000 km$^2$. Approximately 320,000 people (Statistics Canada, 2001c) live in several dozen small communities within that area, in addition to those on several First Nation reserves.

Youth Forensic Psychiatric Services (YFPS) provides service to the area through a clinic in Prince George, staffed primarily with psychiatric social workers and psychiatric nurses, in addition to contracted professionals in several of the region’s communities, many of whom also hold other mental health positions in their community. For families not residing in Prince George, a youth’s involvement with the justice system leads to an additional financial burden on the family: time away from work for court and legal appointments, and travelling expenses when the youth is required to travel for assessment or specialized treatment services not available in their home community.

In addition, when a youth in northern British Columbia is in need of a forensic assessment, the lack of available psychologists and psychiatrists result in families having to travel at times that coincide with the schedules of visiting doctors. Although YFPS makes every effort to coordinate appointments to reduce travel for families whenever possible, because the doctors have full time positions elsewhere in the province, there are many occasions when the schedules of the psychologist and the psychiatrist do not overlap, requiring families to travel to Prince George more than once for the assessment. Due to the limited time the doctors have available to travel to Prince George, travelling to the communities of the family is not efficient; when the doctor travels to the family, only one
youth receives service, but several can receive service when they travel to the doctor. For many families in northern British Columbia, completion of an assessment requires time off work, several hours of driving, as well as food and accommodation expenses.

Further, during several months of the year, travelling to the Prince George clinic from distant communities in the region can be especially taxing due to the inclement weather and poor road conditions. Well-intentioned families, unable to negotiate the distance in winter conditions, occasionally miss their appointments, resulting in delays in the court process. Similarly, there have been incidences in the past few years where the families managed to travel to Prince George by road, but the doctor’s flight into the Prince George airport had been cancelled due to poor weather conditions. In his examination of youth justice in rural areas of Canada, Nuffield (2003) described the situation accurately when he said,

Specialized justice services are in short supply everywhere, and for rural and isolated areas, the difficulty of persuading specialists to travel in, and the costs of bringing them in, are formidable. Among the specialized services needed are psychiatric and psychological assessment and counselling, life skills and anger management programming, and services aimed at sexual deviance, drug and alcohol abuse, and parenting skills. As one British Columbia respondent noted, ‘isolated [people] generally have less access to professional people’ (Sec 4.1.2, ¶2).

Impact on Service Providers

Clinicians working with sexual offenders can experience vicarious traumatization and burnout through exposure to the details of the sexual offending behaviour, and, as a result, they can experience changes in both their sense of trust and safety, and in their interactions with those around them (Kadambi, 1998; Lea, Auburn & Kibblewhite, 1999; Ryan, 1998). Lea et al. (1999) found insufficiencies in training, supervision, and support to
be the primary contributing factors to dissatisfaction of workers and these were linked to the high turnover in staff working with sexual offenders. Kraus (2005) studied 90 mental health professionals to determine if self-care could prevent burnout or compassion fatigue. The results showed that self-care did not strongly influence these, but did influence compassion satisfaction. However, self-care may increase satisfaction from helping. “If therapists are to continue to work with a population which puts them at risk for negative psychological effects, more research is needed to provide valuable information on how to limit or eliminate those effects” (Kraus, 2005, p. 87).

Clinicians working with this population must also possess sufficient compassion and patience to work with involuntary clients and to educate the public, tactfully, about the line of work. Some researchers openly acknowledge the difficulty experienced by sex offender treatment providers because of the social stigma associated with the treatment of this criminal population (Hunter & Lexier, 1998). A question often posed to YFPS clinicians upon explaining their career to a new acquaintance is, “How can you work with those kinds of people?” a question to which this writer responds, “By seeing the person, not just their behaviour.”

Hunter and Lexier (1998) provided an overview of the dilemmas facing sexual offense clinicians in general, focusing specifically on issues such as confidentiality and development of the therapeutic relationship. Unfortunately, they inadvertently perpetuated the assumption that all sexual offense therapists work in metropolitan areas and encounter the same client profiles; they provided no reflection on how geography, access to services, or community acceptance can affect treatment providers in rural areas.
However, Hunter and Lexier's (1998) identification of ethical dilemmas was accurate. Another difficulty facing many clinicians in northern British Columbia is maintaining compliance with professional codes of conduct. The codes of ethics for each of the American Psychological Association (2002), the Canadian Counselling Association (1999), and the Canadian Association of Social Workers (2005) specify that the clinician is to avoid dual relationships with the client, such as counsellor and friend, or counsellor and coach of the client's sports team. Identifying dual relationships as a current issue for British Columbia therapists, Nigro and Uhlemann (2004) identified 39 possible dual relationships a clinician might encounter, and asked 529 counsellors to rate the relationships for perceived ethical appropriateness. Through mailed survey, they received 206 useable responses, and learned the respondents agreed with the expectations of their registering bodies, however there were some significant problems noted.

The researchers acknowledged that they did not take into account demographics of the respondents, nor did they address the conflict for those counsellors who identify a dual relationship as inappropriate, but are in a position where avoidance of the dual relationship is difficult, if not impossible. Dual relationships are difficult to avoid outside of the counselling office in most small communities. For example, most respondents rated it inappropriate for a counsellor to provide counselling to the relatives or friends of a client, yet this is a frequent reality for counsellors in rural areas where access to alternative counsellors is limited. As one contracted psychiatric social worker in northern British Columbia explained,

It’s hard to avoid dual relationships in [a small northern community]. Some days, you can see a youth in your office, then go fill up your car at [a gas station] where the youth’s brother works, go pick up a few things at [a business] where the mother works, and then play [a sport] that night with the
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Youth’s [relative]. Unless I stay home and don’t interact with anyone at all, I can’t avoid running into people that are connected to my clients. And what’s worse, they all know that you are the youth’s counsellor! Even though I haven’t told anyone, the youth and their family have, so people come up to me when I’m out with my family and say they’re glad the youth’s coming to see me for counselling. If I confirmed it, I would be violating my client’s confidentiality, and if I denied it I’d be seen as lying about something that’s common knowledge. All I can really do is smile and say, ‘It’s nice that you care’ and try to change the subject. The code of ethics doesn’t take into account the reality of working in [a small rural community] (Name withheld, personal communications, August 2005).

Nickel (2004) recommends that rural counsellors facing this type of situation must openly discuss their dual relationships with the client in order to establish strategies to reduce the implications and potential risks arising from the overlapping roles in the community.

Differences in responses to the Nigro and Uhlemann (2004) survey were also evident when the age of the respondent was taken into consideration. Answers from older respondents showed they rated some scenarios, such as providing a client with a ride home after a session, as being less an ethical issue than did answers from younger respondents. It is possible that these variations in viewpoints came from experienced clinicians from rural areas who knew that they must overcome the logistics of service delivery in order for clients to access, and benefit, from the intervention.

Literature Review Summary

Adolescents commit more sexual offenses each year in Canada than do adults (Statistics Canada, 2003b). The costs associated with sexual offending by youths are high: there are multiple victims of each sexual offender, as evidenced by the impact on each of the victims, the victims’ families, the offenders’ families, and their communities. The
government of British Columbia spends millions of dollars each year on investigating, processing, incarcerating, supervising, assessing, and treating youths who commit sexual offenses.

In British Columbia, taxpayers cover both the cost of incarceration for adults and the cost of assessments and treatment for youths charged with sexual offenses. Correctional Services Canada (2004) determined the cost to provide sex offender treatment is over seven thousand dollars per year for each participant, and that decreasing recidivism by only 40 sex offenders annually would recoup the costs for continuing programs. In light of the cost for incarceration of one adult offender, a comprehensive assessment and the provision of treatment for the adolescent offender can ultimately be very cost effective.

However, most do not receive treatment specifically addressing sexual offending behaviour due to a variety of reasons: parents not reporting their child’s sexually intrusive behaviours at the onset; lack of victim disclosure, or lack of victim cooperation with the justice system (Christodoulides et al., 2005); police priorities resulting in no charges being laid when the offense is reported (Statistics Canada, 2003a; Soulliere, 2005); crown counsel allowing the youth to plead to a lesser offense in order to get a conviction (Piccinato, 2004); judges passing sentence without the benefit of a comprehensive assessment that speaks to the treatment needs of the youth; probation orders with conditions that do not support necessary interventions; an order that is of insufficient duration to allow for successful completion of treatment; and youths not being held responsible to comply with all the conditions.

Data published to date has shown that, typically, the adolescent sexual offender: is male (Statistics Canada, 2003a); started sexually offending prior to the age of 14 (Falls,
2001), but was first convicted at 15 years (Latimer et al., 2003); was exposed to emotional, physical and/or sexual abuse in the family home (Hunter & Figueredo, 2000; Truscott, 1993); came from a home lacking a sense of safety or stability (Hagell & Newburn, 1996); lacks self-confidence and a sense of personal efficacy (Hudson & Ward, 2000); lacks empathy for others (Burke, 2001); has poor social skills (Maag, 2005); has limited social functioning (Hudson et al., 1999); has attachment difficulties (Ward et al., 1996); and is more likely to have had problems in school (Shields, 2004).

Although adolescents who have some form of cognitive disability are not more likely to sexually offend than a non-disabled youth (Simpson & Hogg, 2001), those that do offend sexually tend to be younger and have often been offended themselves by family members (Holland et al., 2002). In addition, they tend to choose both male and female victims and are less likely to commit sexual offenses involving penetration or violence (Nankervis et al., 2000).

In British Columbia, the Youth Criminal Justice System entrusts Youth Forensic Psychiatric Services (YFPS) with the assessment and treatment of these challenging clients. Assessments involve actuarial and clinical measures. Varieties of tools exist to assist in the assessment, although few have been normed for sensitivity with non-Caucasian or cognitively disabled clients. The assessment reports provide the courts, supervising probation officers, and the treatment clinicians with recommendations for interventions intended to meet the needs of the youth, his family, and the community.

Intervention programs for youths who commit sexual offenses originated from programs intended for adult sexual offenders (Bell, 1994), but research has shown that adolescent offenders differ in many ways from adults (Center for Sex Offender
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Management, 2002). As a result, programming for these youth has developed through trial and error (Grant, 2000) with an eye on the latest empirical findings to guide program development. At YFPS, the four primary objectives of treatment for those who offend sexually are: (i) to reduce the risk of sexual offending, (ii) to improve psychological, social and adaptive functioning, (iii) to treat and control co-morbid conditions where identified, and (iv) to plan, discharge and facilitate integration into the family and/or community (Youth Forensic Psychiatric Services, 2004).

Worling and Curwen (2000) emphasized that the most serious threat to the validity of results is when subjects are not randomly assigned to the treatment and control groups. As is the case with many health-related research studies, there is an issue of randomly assigning subjects to groups when the assignment will result in a subject being denied treatment. This results in control group subjects being limited to those that quit treatment, are on wait-lists for treatment, or who have commit sexual offenses but are not reported to the authorities – obviously, a difficult population to access.

Researchers have attempted to gain a better understanding of this population by identifying common characteristics, developing categorization systems, exploring the impact of learning disabilities on the treatment of the youth sexual offender, and trying to link characteristics to recidivism. In most discussion sections of research in this field, the message from the authors remains consistent: more research is needed to better understand this population and to determine what interventions work best. Further, sexual abuse needs to be recognized as more than a mental health issue; it should also take into account social and political ideals, cultural values, and economic conditions for a holistic approach to the problem (Conte, 1984).
Language also plays an important role in the literature on this topic. Some researchers stress the importance of being aware of how the language used in the treatment of those who sexually offend focuses on the negative, and how many programs focus on the sexual offending behaviour without adequate consideration to the client’s overall functioning (Marshall, Ward, Mann, Moulden, Fernandez, Serran, et al., 2005). They suggest renaming components to be positive and goal oriented, rather than avoidance oriented. Other language issues arise from the lack of consensus on definitions for terms and labels used in the field; comparing subjects or results from research lacking explicit definitions is difficult. Nonetheless, evaluations of the efficacy of interventions with this population have shown that specialized treatment does affect risk to reoffend (Hanson et al., 2002; Lipsey & Wilson, 1998; Reitzel, 2005). However, we are not yet able to draw conclusive findings on the specific variables resulting in treatment effect.

Marshall et al. (2005) claim that instilling hope in the client is paramount to the client’s cooperation and success. Hornsveld and De Kruyk (2005) affirm, the literature on sexual offenders clearly identifies the importance of sexual offense treatment that focuses on general coping and life skills in addition to the client’s specific criminogenic factors; subjects in Mathieu’s (2001) study listed expressing feelings, understanding the reason they committed the offense(s), feeling a sense of belonging, and learning how to better interact with others as the most helpful components of their treatment.

Another factor that may affect treatment outcome is the match between client and service provider. O’Toole (November 5, 2002, personal communications) stated, “Different clients need different types of therapy and therapist characteristics.” Clinicians working with this population are required to have specific skill and knowledge sets, and there is a
limited availability of qualified persons in northern British Columbia. Those clinicians who do choose to provide this service in this region of the province face unique challenges: not only barriers to service delivery, but also personal, social, and ethical dilemmas faced in providing treatment to this population in a northern community.

Conclusions

The treatment of adolescents who sexually offend is a relatively new field, and researchers are recognizing that treatment programs designed for adults are not always the best fit for youths. Although research on the sex offender population has increased in recent years in North America, researchers have conducted a limited number of studies in Canada, with fewer focusing specifically on the identification and treatment of adolescents convicted of sexual offenses in British Columbia (Pang & Sturrock, 1995).

In order to gain a better understanding of the population, I conducted an extensive literature review, including a review of common themes. I noted that almost every article reviewed made reference to a lack of understanding and the need for more research on adolescent sexual offenders. At the conclusion of the literature review, it was apparent that there was general agreement on common characteristics of this population, but lack of consensus in the literature on classification models; treatment efficacy; and factors which predict recidivism. After reviewing the literature, however, I was left with three primary observations. First, the research did not indicate if sexually intrusive youth in remote and rural areas possess the same characteristics that studies completed in metropolitan areas of North America claim are common to the subject population. Numerous researchers attempted to identify common characteristics of sexually intrusive youth, but few drew
their samples from a non-urban population, and none examined the characteristics of sexually intrusive youth in northern British Columbia.

Next, I noticed that treatment efficacy was a popular research topic, however the potential impact of travel distance to access treatment for youths in rural areas was not addressed in the literature. The number of youths having to travel long distances to access YFPS services in northern British Columbia, and the distances travelled, was of particular interest to this researcher, as I was unable to locate any studies that explored this specific requirement for sexual offense treatment in rural areas.

And finally, I noted that the number of studies of this population in rural areas of Canada were limited, and I was unable to locate any that specifically examined the characteristics of youths and their offenses from an ethnic or cultural perspective for treatment planning. Second in representation to Caucasian, the largest ethnic group in rural British Columbia are people of First Nations ancestry. Therefore, in order to provide culturally sensitive treatment to this population, I believed it was important to first determine what, if any, differences exist between youths of the two primary ethnic groups.

This research was designed address these gaps in the literature. As explained previously, the goal of this exploratory research was the development of a profile of those clients referred to northern British Columbia’s YFPS clinic for assessment or treatment for sexual offenses during the past three years for comparison of their characteristics to the characteristics described both in the literature and in a similar study on clients at the YFPS clinic in Burnaby, British Columbia. Completion of this research was expected to lead to the development of a northern client profile, and to the development of better interventions with youth who sexually offend in northern British Columbia by identifying their specific...
needs. In the following chapters I describe the methods of the study, the results, and provide a discussion of the results with recommendations to address the findings.
CHAPTER THREE

Methodology

Design

I chose a quantitative approach for this study in accordance with Rubin and Babbie (1993), who stated that quantitative methods “may be more appropriate... when we seek to verify hypotheses or describe with precision the characteristics of a population” (p. 30). The quantitative approach chosen, a non-experimental descriptive multiple-case study, allowed for comparison of the findings with quantitative studies in the literature, particularly studies previously conducted by researchers in Youth Forensic Psychiatric Services (YFPS) (Regan et al., in press). Also, by using a quantitative approach, I was able to reduce the likelihood of compounding subjective bias during the collection of data already subject to bias by the recorder of the original information. Data for this study was collected from case files only.

Case File Selection

The sample subjects were adolescents at the time they accessed service from the northern branch of Youth Forensic Psychiatric Services (YFPS) ($M = 15.83$ years, $SD = 1.43$). Each of the subjects selected had confessed to, or were convicted of, one or more violations of the Criminal Code of Canada relating to sexual offending (see Appendix 2). The ethnic composition of the sample consisted primarily of Caucasian (54.7%) and First Nation (44.2%) youths. Of 108 youths referred to the northern branch of Youth Forensic Psychiatric Services (YFPS) for assessment and/or treatment between January 1, 2002 and...
December 31, 2005, the case files of 95 were included in this study. Of the 13 excluded, four had insufficient file information, three were for adults referred for crimes committed during adolescence, and the remaining six consisted of files for youths referred to YFPS, but who did not attend to access service.

The data used for comparison with the northern offenders came from an unpublished study conducted in Burnaby, British Columbia (Regan, Spidel, Gretton, Catchpole, & Douglas, 2003), which examined 118 adolescent sexual offenders who attended Forensic Psychiatric Services in Burnaby, British Columbia for treatment between October 1990 and June 1999. The Burnaby YFPS clinic covers the cities of Burnaby, Greater Vancouver, Coquitlam, Port Coquitlam and Port Moody. The study by Regan et al., which provided a sample of sexual offenders in the metropolitan area of British Columbia, was a between groups comparison of the sexual offense treatment program participants. The comparison was based on which treatment group the youth had attended: the regular Sexual Offense Treatment Program, or a Special Needs (SN) program, which differed primarily in how the material was presented to the youths.

The authors explained that the youth assigned to their SN program, \( n = 60 \) were chosen by the clinicians based on the youth’s capacity for learning, as determined by psychometric testing, or on the youth’s need for extra support \( (M = 15.7 \text{ years}, SD = 1.4) \), while the youths in the regular program \( n = 58 \) were randomly selected from participants of that program \( (M = 15.7, SD = 1.5) \). The decision to place the Burnaby youths into one of two groups was based primarily on clinician decision without a means for replication of those decisions. For that reason, the data from the Burnaby SN and regular groups was
used collectively as a single group for comparison with the data from this northern study, in which no distinction was made as to the type of program the youth received.

According to the data provided from the Burnaby study, two of the cases were under the age of 12 at the time of the index offense, and four of the cases attended YFPS for assessment or beginning of treatment after age 19. Those six cases were not included in the data analysis because they fell outside of the limits set for the Northern study. An additional two cases in the Burnaby study were excluded from further analysis because they did not include a date of birth.

_File Information_

The file information from the Burnaby study was provided to me in the form of a Statistical Product and Service Solutions (SPSS), data file. I obtained information on the clients in the northern study directly from the YFPS client files; there was no direct contact with participants for the purpose of this study. These files characteristically contained a referral form, a report to Crown Counsel, victim statements, collateral information, progress notes, assessment reports, external reports, work completed by the youth during assessment or treatment, and copies of all legal documents relating to the file.

The referral form, completed by the referring party, identified the youth and his offenses, the name of his legal guardian, and contact information. In addition, it specified the purpose of the referral: assessment, treatment, or both. The Report to Crown Counsel, prepared by the investigating member of the Royal Canadian Mounted Police (RCMP), advised Crown Counsel of the circumstances of the offense and included a detailed description of the event; it usually included the names of any witnesses, any related prior
involvement with the RCMP, and recommendation for charges based on the applicable violations of the Criminal Code of Canada. The victims' statements, transcribed reports of interviews conducted by a member of the RCMP with the victims, witnesses, and often the victim's legal guardian/s, were also included.

The collateral information section of the file included all information collected, with the written consent of the client, from persons and agencies outside of YFPS specifically for the purpose of an assessment. This information typically included the client's medical and birth records, school records, a social history from the primary caregiver, prior assessments or evaluations prepared by other agencies, and information from government child protection and family service files in those cases where the youth had prior involvement with those services. In addition to collateral information collected for the purpose of the assessment, the files often contained reports submitted by external agencies that had ongoing involvement with the client.

Primarily authored by the interviewing clinicians of the assessment team and/or the primary treatment clinician, the progress notes detailed interactions with the client, session contents, the services provided, and the client's response to those services. Interview and progress notes included information obtained during interviews with the youth, as well as from interviews with his caregivers or legal guardians, or with other external parties holding information about the youth's history and development.

The assessments completed by the YFPS clinicians characteristically included a comprehensive psychosocial assessment, psychometric testing, and psychological assessment. A psychiatric assessment was included in those files where a psychiatric
assessment was specifically requested by the court, where the assessing psychologist requested it, or where psychiatric consult was available.

Worksheets, journals or other materials completed by the youth during involvement with the clinic were saved on the youth’s file, but were not accessed for the purpose of this study. Typically, the file section for legal forms contained, where applicable, the Order to Assess and Report, a Warrant of Committal for those youths in custody at the time of involvement, a copy of the youth’s Probation Order or Extra Judicial Sanctions Order, and the Order of Proceedings.

Procedure

Each subject’s file was assigned a confidential identification number for data collection purposes. As each file was reviewed, it was noted if the subject had been referred to YFPS for assessment, treatment, or both, and individual client information retrieved from the file was coded and recorded on an individual client data sheet, created for use in this study (see Appendix 4). The time spent reviewing each file varied from 25 minutes for files with minimal data to over 220 minutes for files with multiple volumes, numerous assessments or an abundance of collateral information; reviewing files for data collection took approximately 200 hours.

Coded data from the individual client data collection sheets was entered into electronic data files, and stored on the Government of British Columbia’s secure network server in password-protected files. The coded data sheets were kept in a locked filing cabinet at the Youth Forensic Psychiatric Services office. A copy of the summarized data in electronic format was stripped of all non-coded or potentially identifying information.
then password-protected for use in data analysis conducted outside of the government office.

Data collected

The data sheets included six main sections: client demographics, service access, client history, diagnoses, offense information, and psychometric testing results. Unless otherwise specified, the information for each variable was recorded using the following scoring method: 0 for No, 1 for Yes, 99 for Unknown or Information not available, and X for not applicable.

Section one, client demographics, included five variables: gender, ethnicity, age at index offense, age at time of referral, and age at the time of closure of the youth’s assessment or treatment file at YFPS. The youth’s ages for the three recordings were calculated based on the youth’s date of birth, and converted to age in years, months, and days by an on-line calendar calculator program (http://calendarhome.com). The variable data was recorded as total age in months, rounding up for those with 29 or more days in the remainder of the calculation. Ethnicity was identified either by the referring party on the referral form, or by the youth during the assessment. Youths who self-identified as Metis or Aboriginal were recorded as First Nations regardless of the presence or absence of formal documentation of status.

The two variables recorded in section two, service access, identified the closest YFPS clinician (employee or contractor) for treatment follow-up, as well as the distance the youth was required to travel to access the Prince George YFPS clinic for assessment and primary treatment. Due to the very limited door-to-door delivery service provided by
Canada Post in Northern British Columbia, and due to the frequent number of clients residing in rural areas without formal street addresses, most client addresses on file consisted of a post office box, and not a physical street address. Distances were calculated with the assistance of an on-line mapping program (http://ca.maps.yahoo.com) using either a street address or the Canada Post assigned postal codes to determine the kilometric distance from the client’s residence to the YFPS service. The distance was recorded as a single digit corresponding to one of seven ranges of distances in kilometres.

The ten variables in section three, client history, focused on the youth’s behaviour prior to involvement with YFPS as well as formal diagnosis of a learning disability, attendance at an alternate school, history of learning difficulties, history of behaviour problems at school, attempted suicide, and self-injurious behaviours. The highest grade completed prior to YFPS involvement was recorded as *Grade Number*.

Alcohol use and drug use were individually coded based on the youth’s level of use of the substance(s). No history of alcohol or substance use was coded as *No Use*. A history of one time use, a brief period of minimal experimentation, or minimal use in social settings, not to the point of intoxication or serious impairment resulting in negative consequences (socially or physically), was coded as *Social Use*. A history of using a substance alone in an attempt to escape problems, use to the point of intoxication or serious impairment, or use resulting in negative consequences (socially or physically), was coded as *Abuse*. Finally, a history of the youth actively seeking repeated substance use despite repeated negative consequences, with repeated intervention attempts by family or friends, was coded as *Addiction*. When identified, *Substance* indicates the subject’s most frequently used non-prescribed substance.
Data collected for completion of the fourth section on the data collection sheet, diagnoses, included presence or absence of a prior diagnosis of ADHD, mental illness, conduct disorder, gestational exposure to alcohol, or confirmed diagnosis of fetal alcohol syndrome/fetal alcohol effect. In addition, any diagnoses assigned as a result of the YFPS assessment were recorded under the DSM-IV\(^7\) code.

The fifth section, offense information, included the gender and age of each victim identified in the index offense, including the location of the offense, the victim’s relation to the offender, and the Criminal Code of Canada charges, which identified the type of sexual offense. In those cases where the file identified multiple victims, despite only one listed on the index offense, information for all identified victims was included on the sheet. Recorded details about the crime included whether or not the youth was babysitting, used threats, or was under the influence of alcohol or non-prescribed drugs at the time of the sexual offense. Data collected for this section also included if the youth had prior involvement with the RCMP, a history of prior offenses (any crimes), or prior convictions for sexual offending.

The sixth section of the data collection sheet, specific to the psychometric testing results, was further divided into separate sections, specific to the most commonly used tests: (i) the Wechsler Intelligence Scale for Children (WISC), (ii) the Wechsler Adult Intelligence Scale (WAIS), and the (iii) the Wechsler Individual Achievement Test (WIAT). The Wechsler Intelligence Scale for Children (WISC) is used to determine the youth’s intelligence score. It is designed for use with clients between the ages of 6 years and 16 years, 11 months. The Wechsler Intelligence Scale for Children, third edition (WISC-III) underwent several changes before being released as the WISC-IV: the Verbal

IQ (VIQ), Performance IQ (PIQ) and Freedom from Distractibility indices of the WISC-III were renamed to the Verbal Comprehension Index (VCI), Perceptual Reasoning Index (PRI), and the Working Memory Index (WCI), respectfully (Williams, Weiss & Rolfhus, 2003a, 2003b). The name of the Processing Speed Index was not changed. The validity of the four index scores has been evidenced in clinical and nonclinical studies (Zhu et al., 2004), with the majority of research reports on these tests originating in the United States. I was unable to locate studies comparing results of rural youths tested using Canadian-normed versions.

The Wechsler Adult Intelligence Scale (WAIS) is used to measure intelligence in those 17 years and older, and the Wechsler Individual Achievement Test second edition (WIAT-II) is used to measure academic skills. The WIAT-II is intended for use with those between the ages of 4 and 85 years (Harcourt Assessment Company, 2002).

Analysis of the Data

The collected data was organized and analysis was conducted with the use of two software programs: Microsoft Excel, Small Business Edition 2003, and Statistical Product and Service Solutions (SPSS), version 13. A confidence interval of 95% was used for all analyses unless otherwise specified.

Many studies focusing on the characteristics of this population provide the research results in the form of descriptive statistics. For this reason, measurements of central tendencies, data variations, skews, and frequencies were generated to present the data and to provide a method of comparing the results to findings in the literature. In order to compare the results of this study to the findings of the Burnaby study, a combined data file
was created in SPSS. From the combined data file, geographical sample and ethnic comparisons were made with the use of chi square and analysis of variance, in addition to the descriptive statistics. Due to some categories having less than five cases, a Kruskal-Wallis analysis was performed instead of a chi square for those analyses. Data analyses included the offender group as a whole, as well as closer examinations of the two primary ethnic compositions within the larger group, and the characteristics of those individual members.

Prime purpose of the current study was the development of a profile of the clients accessing services through Youth Forensic Psychiatric Services (YFPS) in Northern British Columbia. Coupled with the goal of providing culturally sensitive services throughout the province, the profiling of clients required that data analysis also focus on offender ethnicity to assist with service planning. In order to determine if there was a difference in the cases based solely on ethnicity, an analysis of variance based on ethnicity was conducted on the combined studies. I present much of the data in light of the two primary ethnic backgrounds in order to explore possible ethnic differences that may indicate ways in which YFPS could provide more culturally specific service to these clients in Northern British Columbia.

For the purposes of the Northern study, I coded four main variables for each victim when possible: gender, age, relation to their offender, and the location of the offense. In the Burnaby study, the researchers coded victim information categorically. For example, they coded “1” if there was one index offense victim and “2” if there were more 2 or more index offense victims, without specifying the total number or including all details for each victim. This resulted in some loss of data which prohibited victim comparisons between the
studies. Due to these differences in coding, the victim data is presented separately for each study with direct comparisons noted when appropriate.

The data from the Burnaby researchers on alcohol and drug use was coded under four variables each: history of use, severity of use, frequency of use, and interference in daily functioning as a result of use. This data was collapsed and recoded for comparison against the Northern study variables of: no history of use, social use, abuse, or addiction. The multiple-drug use categories in the Burnaby study did not detail which drugs were used specifically, therefore direct comparisons with the northern sample based on the most frequently used type was not possible.

**Ethics**

**Consent**

Government policy, provincial legislation, and federal statutes protect information contained in the client files belonging to YFPS. The former Young Offender’s Act (1984) and the current Youth Criminal Justice Act (2002) grant anonymity to youths in conflict with the law. As YFPS’ clients are referred for service following conflict with the law, their identity continues to be protected. Contacting former clients to request permission to access their file information would be, in itself, a violation of their rights under the above named legislation. As a result, I could not obtain the individual consent of the clients.

However, the Ministry for Children and Family Development, and specifically, YFPS, retain ownership of the client files. Access for research purposes is granted only to authorized individuals following approval of the Provincial Evaluation and Research Committee. I, as an employee of Youth Forensic Psychiatric Services, was required to obtain approval from the Provincial Evaluation and Research Committee, the manager of
the northern region of YFPS, and from the University of Northern British Columbia’s own Research Ethics Board in order to access the confidential client files for the purpose of this study. All information was collected from client files belonging to YFPS (See Letter of Consent, Appendix 3).

Protection of data

Data collection from the original client files was completed in the government office. Original client files were maintained in the secured file room of the Youth Forensic Psychiatric Services office where client files are stored. The coded data sheets were kept in a locked filing cabinet at the Youth Forensic Psychiatric Services office. Electronic client information is stored on the Government of British Columbia’s secure network server in password-protected files.

Data from the individual client data sheets was entered into electronic data files, and also stored on the Government of British Columbia’s secure network server in password-protected files. A copy of the summarized data in electronic format was stripped of all non-coded or potentially identifying information, and was then password-protected and encrypted for use in data analysis conducted outside of the government office.

Limitations of the study

Generalization.

Generalizations of the findings of this study are limited to the clients referred to Youth Forensic Psychiatric Services (YFPS) during the study period. An accurate sample of the entire population of sexually offending adolescents in northern British Columbia
cannot be determined because data is not available on adolescents who have sexually intrusive behaviours but who have yet to become involved with the justice system or YFPS.

The data for the study was limited to a specific time period, January 1, 2002 to December 31, 2005, producing a snapshot of clients during that time span. It is possible that the characteristics of the study population may differ over time in response to changing socioeconomic factors in the study region.

Data accuracy

I retrieved all of the information for the Northern study from client files. Although every effort was made to ensure data accuracy, it is important to note that some of the data collected for this study came from file information previously collected by clinicians during an interview of the youth, the youth’s guardian, or both. Unless the information provided to the assessing clinician was supported or contradicted by reliable collateral information, such as birth and medical records, the information collected was unverified. Although overlaps in the information from the various sources provided some consistency in the data, information provided by the youth or guardian may be inaccurate due to faulty recall, subject-expectancy bias, lack of direct knowledge, or intentional omission of self-deprecating details.

Further, given that information provided during an assessment could be included in a report submitted to the court or a supervising probation officer or, as required by law, be reported to the authorities, there exists the risk of biased disclosures by youths and guardians, and the avoidance of any self-incriminating details. Clinician bias and recording
error may also have influenced the accuracy of that data collected from progress notes, summary reports, or discharge recordings.

**Non-random sample**

The cases chosen for inclusion in this case were not drawn from a random sample, but included all the cases in the population meeting the specified criteria. Inclusion of all cases was selected to provide more accurate data than a sample of the population would have allowed. No differentiation was made between the types of sexual offense treatment program the youth attended. The comparison data from the Burnaby study included 118 males who attended the Sexual Offense Treatment Program in Burnaby, British Columbia, between October 1990 and June 1999. Of those 118 cases, 60 had been enrolled in a Special Needs treatment group and the remaining 58 cases were drawn randomly from the regular treatment group. For the purposes of the comparison, the 118 cases were considered as one group for comparison to the 95 cases from the Northern study.
CHAPTER FOUR

Results

Introduction

In this chapter, I refer to the data collected in northern British Columbia as *The Northern Study,* and I refer to the information collected by my colleagues at the Burnaby Youth Forensic Psychiatric Services (YFPS) clinic, as *The Burnaby Study.* The results are presented in similar order to the categories of the literature review, that is: demographics, access to service, client characteristics, victim profile, and offense information.

**Demographics**

*Ethnicity*

*Northern study.* Ethnicity was reported for each of the 95 northern cases, and initial data analysis revealed the youths were comprised primarily of two major ethnic groups: Caucasian or First Nations ancestry. Caucasians comprised the majority of the study population (n=52), with the remainder being of First Nations (n=42) and 1 youth of another ethnic background (see Table 3).

*Burnaby study.* As presented in Table 3, ethnicity was reported for 92 of the 110 cases from the Burnaby study (Regan et al, in press). Of those 92, there were 59 Caucasians, 24 First Nations, 3 Asians, 1 East Indian, 1 Latino, and 4 youths described as being of mixed race ancestry.
Study comparisons. Analysis of the nominal variables of ethnicity revealed some differences in respect to ethnic composition of the two samples ($\chi^2(2, N = 187) = 11.705, p = .003$). Specifically, 26.1% of Burnaby’s sample consisted of First Nation clients compared to the Northern study’s 44.2% First Nation clients.

Gender and Ages

Northern study. Males comprised 93 of the 95 cases in the northern sample. At the time of their index offense, the youths ranged in age from 12 years, 0 months to 17 years, 8 months (see Table 4). There were no statistically significant differences between the northern ethnic groups on the variables of: age at index offense ($F (3, 94) = 1.071, p = .365$); age at referral ($F (3, 94) = .249, p = .862$); or length of involvement with the Prince George Youth Forensic Psychiatric Services (YFPS) clinic ($F (3, 94) = 1.366, p = .260$). The average length of time from index offense to referral to the northern YFPS service was
1.4 years ($SD=1.19$). The longest duration between offense to referral for service was 4.81 years.

Table 4

*Ages at Time of Index Offense, Referral to YFPS, and Discharge (in years)*

<table>
<thead>
<tr>
<th></th>
<th>Northern Study</th>
<th>Burnaby Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>Index offense age</td>
<td>$n$</td>
<td>95</td>
</tr>
<tr>
<td>$M$</td>
<td>14.42</td>
<td>14.21</td>
</tr>
<tr>
<td>$Md$</td>
<td>14.33</td>
<td>14.29</td>
</tr>
<tr>
<td>$SD$</td>
<td>1.45</td>
<td>1.39</td>
</tr>
<tr>
<td>Referral age</td>
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<td>95</td>
</tr>
<tr>
<td>$M$</td>
<td>15.83</td>
<td>15.79</td>
</tr>
<tr>
<td>$Md$</td>
<td>16.00</td>
<td>16.00</td>
</tr>
<tr>
<td>$SD$</td>
<td>1.47</td>
<td>1.45</td>
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</tr>
<tr>
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<td>1.41</td>
<td>1.58</td>
</tr>
<tr>
<td>$Md$</td>
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<tr>
<td>$SD$</td>
<td>1.19</td>
<td>1.37</td>
</tr>
<tr>
<td>Discharge age</td>
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<td>80</td>
</tr>
<tr>
<td>$M$</td>
<td>17.49</td>
<td>17.35</td>
</tr>
<tr>
<td>$Md$</td>
<td>17.54</td>
<td>17.17</td>
</tr>
<tr>
<td>$SD$</td>
<td>1.56</td>
<td>1.49</td>
</tr>
</tbody>
</table>

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Youth who sexually offend 138

Table 4 (continued)

*Ages at Times of Index Offense, Referral to YFPS, and Discharge (in years)*

<table>
<thead>
<tr>
<th>Length of service</th>
<th>Northern Study</th>
<th>Burnaby Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>n</td>
<td>80</td>
<td>44</td>
</tr>
<tr>
<td>M</td>
<td>1.42</td>
<td>1.64</td>
</tr>
<tr>
<td>Md</td>
<td>1.25</td>
<td>1.50</td>
</tr>
<tr>
<td>SD</td>
<td>1.26</td>
<td>1.18</td>
</tr>
</tbody>
</table>

The average length of involvement with YFPS for assessment purposes was 12.3 months, \((SD = 13.19\text{ months})\), with a range of 3.00 to 46.00 months. For treatment purposes, the average length of involvement was 19.36 months \((SD = 14.25\text{ months})\) with a range of 7.00 to 58.00 months, and the average length of involvement for assessment and treatment through YFPS was 20.25 months \((SD = 14.28\text{ months})\) with a range of 2.00 to 78.00 months.

**Burnaby study.** Males comprised 100% of the 118 cases in the Burnaby study (see Table 4). In the remaining Burnaby cases, the youths’ ages at the time of their index offense ranged from 12.08 to 17.75 \((M = 15)\). The average length of time between index offense and referral for assessment was 8.64 months, with a range of -2.91 to 4.81. The length of involvement with the YFPS clinic in the lower mainland ranged from one to 62 months \((M = 22.69\text{ months})\).
Study comparisons. A one-way ANOVA revealed significant differences between the Northern and Burnaby studies for both age of offense, \( F = (1, 202) = 8.089, p = .005, r = .20 \), and time passed from age of offense to the age at referral, \( F = (1, 201) = 21.566, p = .000, r = .31 \). The average age when the youths committed their index offense was 15 years in the Burnaby study, and 14.42 years in the Northern Study. The average time lapse between offense to referral in the Burnaby study was 8.64 months, while the mean time lapse in the Northern study was 16.8 months.

Access to Services

Northern study. Youth Forensic Psychiatric Services conducts assessments and primary treatment programs for sexual and violent offenders at the YFPS clinic in Prince George. Contractors in surrounding communities provide follow-up treatment to graduates of the primary treatment programs, for relapse prevention, as well as general mental health services for clients in and around their individual communities. Between January 1, 2002 and December 31, 2005, Youth Court and Probation Officers referred youths to the northern branch of YFPS for one of three options: a formal assessment\(^8\) (10.5%), treatment purposes (12.6%), or for both a formal assessment and treatment services (76.8%).

Over 70% of the clients were able to access a YFPS counsellor within 25 kilometres of their home for post-assessment or non-primary treatment services\(^9\) (Table 5). However, 58.8% of the Caucasian youths and 76.2% of the First Nation youths were required to

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\(^8\) Although all youth referred to YFPS for treatment purposes receive a treatment-needs assessment, the formal assessment results in a written report sent back to the referring agent, outlining the findings of the youth’s psychometric testing results, psychosocial assessment, and psychological/psychiatric assessment interviews.

\(^9\) Primary treatment includes the Sexual Offense Treatment Program and the Violent Offense Treatment Program – programs which require the youth to attend group and individual sessions in Prince George.
travel substantially farther in order to access assessment or primary sexual offender treatment services at the Prince George clinic.

Specifically, 31% of the First Nation clients were required to travel over 500 kilometres for assessment or primary treatment, while 4% of the Caucasian clients had to travel as far. A Kruskal-Wallis analysis of variance revealed the differences between ethnic groups for distances travelled to obtain assessment and primary treatment was significant, \( \chi^2 (1) = 5.489, p = 0.019 \).

<table>
<thead>
<tr>
<th>Distance from home</th>
<th>First Nations</th>
<th>Caucasian</th>
<th>First Nations</th>
<th>Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 25 km</td>
<td>24</td>
<td>37</td>
<td>71</td>
<td>75</td>
</tr>
<tr>
<td>25-100</td>
<td>0</td>
<td>4</td>
<td>14</td>
<td>12</td>
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<td>101-200</td>
<td>12</td>
<td>8</td>
<td>10</td>
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</tr>
<tr>
<td>201-300</td>
<td>10</td>
<td>21</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>301-400</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>401-500</td>
<td>17</td>
<td>25</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>&gt; 500 km</td>
<td>31</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*Study comparisons.* A comparison of the distances travelled by the clients in the two studies was not possible because the Burnaby study did not collect specific data on the
distances travelled by their clients to access their services. However, given the geographical areas serviced by the Burnaby clinic, it is estimated the furthest distance a client would need to travel for primary treatment at that clinic is under 35 kilometres.

Client Characteristics

Intellectual Functioning

Northern study. A measure of intellectual functioning was available for 89 of the northern cases (94.7%): 39 First Nations and 50 Caucasian youths. The mean full-scale intellectual score (FSIQ) for all the youths was 84.37 (SD = 15.83; min.36, max 124; skew = -.219, ses = .255; kurtosis = .654, sek = .50) (see Table 6). The mean FSIQ for youths of First Nations ancestry was 79.36 (SD = 14.42), with a range of 76 (min. 36, max 112; n = 39). The Caucasian youths had a mean FSIQ score of 88.28 (SD = 15.54), with a range of 72 (min. 52, max 124; n = 50). Analysis of variance shows a significant difference between the ethnic groups on the FSIQ variable, F(1, 88) = 8.80, p = .004, (r = .30).

The mean overall verbal IQ (VIQ) and performance IQ (PIQ) scores for the northern sample were 82.53 (SD = 16.90, n = 86, ) and 87.45 (SD = 17.48, n = 86), respectively. The difference between the two primary ethnic groups for VIQ was significant, F(1,83) = 9.41, p = .003, (r = .32), with no significant difference for PIQ, F(1, 83) = 2.69, p = .105. Of those cases with available intelligence function scores (n = 89), 15.38% had a FSIQ <70. The cases with a FSIQ under 70 were comprised of 23.07% of the First Nation youths (n = 9) and 10% of the Caucasian youths (n = 5).

Table 6

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<table>
<thead>
<tr>
<th>Psychometric Testing Results</th>
<th>Northern study</th>
<th>Burnaby study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>Full Scale (FSIQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>91</td>
<td>50</td>
</tr>
<tr>
<td>M</td>
<td>84.37</td>
<td>88.28</td>
</tr>
<tr>
<td>SD</td>
<td>(15.83)</td>
<td>(15.54)</td>
</tr>
<tr>
<td>FSIQ &lt; 70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>% of total</td>
<td>15.38</td>
<td>10.00</td>
</tr>
<tr>
<td>Verbal IQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(VIQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>86</td>
<td>49</td>
</tr>
<tr>
<td>M</td>
<td>82.53</td>
<td>87.10</td>
</tr>
<tr>
<td>Performance IQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(PIQ)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>86</td>
<td>49</td>
</tr>
<tr>
<td>M</td>
<td>87.45</td>
<td>89.94</td>
</tr>
<tr>
<td>SD</td>
<td>(17.47)</td>
<td>(15.88)</td>
</tr>
</tbody>
</table>

C = Caucasian  FN = First Nations

**Burnaby study.** The FSIQ was available for 83 cases in the Burnaby study, including 62 of the First Nation and Caucasian cases. The overall mean FSIQ for the sample was 86.75 ($SD = 14.47$) with a range of 69 (min = 49, max = 118, skew = -.019, ses = .264, kurtosis = -.061, sek = .523).
The mean FSIQ for youths of First Nations ancestry in the Burnaby study was 77.88 (SD = 10.14, min = 56, max = 97, n = 16), compared to a mean FSIQ of 88.76 for the Caucasian cases (SD = 13.21, min = 55, max = 113, n = 46), a mean difference of 10.88 points. Analysis of variance shows the difference between these two ethnic groups for FSIQ was significant, \( F(1, 60) = 8.979, p = .004, (r = .36). \)

The mean VIQ and PIQ for the combined two ethnic groups of interest were 84.27 (SD = 13.22, n = 62) and 90.94 (SD = 14.34, n = 62), respectively. An analysis of variance of the VIQ of the First Nation and Caucasian cases in the Burnaby study \( (M = 75.38, SD = 8.85, n = 16) \) and \( (M = 87.37, SD = 13.15, n = 46) \) respectively, showed the difference was significant, \( F(1, 60) = 11.44, p = .001 (r = .40). \) However, there was no significant difference found in an analysis of variance of the performance intelligence quotient (PIQ) based on ethnicity in the Burnaby study \( (M = 86.00, SD = 12.88, n = 16) \) and \( (M = 92.65, SD = 14.55, n = 46) \) respectively, \( F(1, 60) = 2.621, p = .111). \)

**Study comparisons.** The comparison of means between the two studies revealed no significant differences on the variables of FSIQ, \( F(1, 171) = 1.007, p = .317; \) VIQ, \( F(1, 166) = .499, p = .481; \) or PIQ, \( F(1, 167) = 1.998, p = .159, \) (see Table 7).

Levene’s test for homogeneity of variance for the FSIQ scores from both studies showed the groups were equal \( (p = .555). \) There was no difference based on number of cases with an FSIQ under 70 points, as determined with a Kruskal- Wallis analysis, \( \chi^2(1, N = 173) = 2.042. \)

An ANOVA showed significant differences between the First Nation and Caucasian cases for two of the three psychometric measures: FSIQ, \( F(1, 149) = 16.10, p = .000, (r = .31) \) and VIQ, \( F(1, 144) = 18.47, p = .000, (r = .34). \) The performance intelligence quotient
Table 7

*ANOVA Comparisons of IQ Results*

<table>
<thead>
<tr>
<th>Source</th>
<th>$df$</th>
<th>F</th>
<th>$\eta$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Burnaby study to Northern study comparison</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Scale IQ</td>
<td>1</td>
<td>1.007</td>
<td>.077</td>
<td>.317</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>171</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal IQ</td>
<td>1</td>
<td>.499</td>
<td>.055</td>
<td>.481</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>166</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>167</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance IQ</td>
<td>1</td>
<td>2.00</td>
<td>.109</td>
<td>.159</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>167</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. First Nation to Caucasian youth comparison</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Scale</td>
<td>1</td>
<td>16.10</td>
<td>.312</td>
<td>.000</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>149</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal</td>
<td>1</td>
<td>18.47</td>
<td>.337</td>
<td>.000</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>144</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>145</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>1</td>
<td>4.31</td>
<td>.170</td>
<td>.40</td>
</tr>
<tr>
<td>Between Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>144</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>145</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(PIQ) analysis showed a less significant difference $F(1, 144) = 4.31, p = .040, (r = .17)$ (Table 7).

**School Performance**

*Northern study.* The mean highest grade completed by youths prior to YFPS involvement was Grade 8 ($M = 8.58; SD = 1.592; skew = -.061; kurtosis = -0.192$), with 38.7% of the cases having a history of attendance at alternate school\(^{10}\) programs (see Table 8). Overall, 78.5% of all the youths had a history of behavioural problems school, although there was no significant difference based on ethnicity ($\chi^2 (2, N = 93) = 1.030, p = .597$).

School records revealed 72% of the Northern youths had a history of learning difficulties, although only 47.3% had received the formal diagnosis of a learning disability.

In a comparison of northern cases based on ethnicity, test results found that, compared to Caucasian cases, those of First Nations ancestry had higher proportions of learning difficulties, ($\chi^2 (2, N = 93) = 9.120, p = .010; r = .32$), and diagnosed learning disabilities, ($\chi^2 (2, N = 93) = 8.178, p = .017; r = .30$).

*Burnaby study.* The mean highest grade completed prior to referral to YFPS was grade 8 for the Burnaby study, ($M = 8.64; SD = 1.409; skew = -.233; kurtosis = .782$) with 42.86% of the youths having a history of alternate school attendance. General learning difficulties and problem behaviours were not specifically coded in the Burnaby study, however 54.8% were noted to have a learning disability, as shown in Table 8.

\(^{10}\) Alternate schools are defined by the British Columbia Ministry of Education as “Programs that meet the special requirements of students who may be unable to adjust to the requirements of regular schools.” They are under the direction of the School Board and do not include charter or magnet schools.
Table 8

School Performance

<table>
<thead>
<tr>
<th></th>
<th>Northern Sample</th>
<th>Burnaby Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>Full Scale IQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>83.51</td>
</tr>
<tr>
<td>(SD)</td>
<td></td>
<td>(17.99)</td>
</tr>
<tr>
<td>Highest grade</td>
<td></td>
<td>M = 8.58</td>
</tr>
<tr>
<td>Alternate school</td>
<td></td>
<td>38.70%</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td></td>
<td>72.00%</td>
</tr>
<tr>
<td>Learning disability</td>
<td></td>
<td>47.30%</td>
</tr>
<tr>
<td>Problem behaviours</td>
<td></td>
<td>78.50%</td>
</tr>
</tbody>
</table>

Study comparisons. Analysis of variance for the variable of highest grade completed revealed no significant differences between the two studies, $F(1, 195) = .076, p = .783$. Similarly, no significant difference was found on highest grade completed based on ethnicity, $F(1, 159) = 2.714, p = .101$. In respect to the presence of a learning disability, there was no significant difference between the number of cases with a diagnosed learning disability in the sample populations, ($\chi^2(1, n = 182) = 1.43, p = .231$), however, there was a significant difference found between the number of diagnosed cases of learning disability in a comparison of Caucasian to First Nation cases, ($\chi^2(1, 151) = 8.315, p = .004, r = .24$).
Drug and Alcohol Use

Northern study. Marijuana (47.31%) and alcohol (7.53%) were the two most used substances for both ethnicities in the northern sample (Table 9). The third most commonly used substance for First Nation cases was inhalants (4.75%) while crystallized cocaine ("crack") was the next most commonly used substance by Caucasians (1.96%). There was a strong correlation between the use of alcohol and use of drugs ($r = .70$, significant at the 0.01 level, 2-tailed). In the northern sample, 28.57% of the youths had a history of using alcohol socially, with an additional 32.97% meeting the criteria for alcohol abuse.

<table>
<thead>
<tr>
<th>Substance</th>
<th>First Nations</th>
<th>Caucasian</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>52.38%</td>
<td>43.14%</td>
<td>47.31%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>7.14%</td>
<td>7.84%</td>
<td>7.53%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>4.76%</td>
<td>0.00%</td>
<td>2.15%</td>
</tr>
<tr>
<td>Non Rx</td>
<td>2.38%</td>
<td>0.00%</td>
<td>1.08%</td>
</tr>
<tr>
<td>&quot;Crack&quot;Cocaine</td>
<td>0.00%</td>
<td>1.96%</td>
<td>1.08%</td>
</tr>
</tbody>
</table>

Although more First Nations youths (40.48%) had a history of alcohol abuse in comparison to Caucasian youths (25.49%), analysis showed no significant differences on the overall use of alcohol based on ethnicity of the youth, ($\chi^2 (2, N = 91) = 2.946, p = .229$). There was also no significant difference between the ethnic groups in respect to the use of substances, ($\chi^2 (3, N = 91) = 1.528, p = .676$), however it was noted that none of
the clients in the northern sample met the criteria for addiction to alcohol (see Definitions, Appendix 2).

*Burnaby study.* The majority of the cases in the Burnaby study indicated social use for both alcohol (56.7%) and drugs (55.2%), with more clients of Caucasian ethnicity indicating social use of alcohol (29.9%) than clients of First Nations ancestry (11.9%). In the Burnaby study, 9% met the criteria for addiction to alcohol, with none of the Burnaby cases scoring *no use* for alcohol (see Table 10).

**Table 10**

*Drug and Alcohol Use*

<table>
<thead>
<tr>
<th></th>
<th>Northern Sample</th>
<th>Burnaby Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>C</td>
</tr>
<tr>
<td>Alcohol use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no use</td>
<td>38.00%</td>
<td>23.90%</td>
</tr>
<tr>
<td>social</td>
<td>29.30%</td>
<td>17.40%</td>
</tr>
<tr>
<td>abuse</td>
<td>32.60%</td>
<td>14.10%</td>
</tr>
<tr>
<td>addiction</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no use</td>
<td>41.30%</td>
<td>26.10%</td>
</tr>
<tr>
<td>social</td>
<td>26.10%</td>
<td>14.10%</td>
</tr>
<tr>
<td>abuse</td>
<td>31.50%</td>
<td>14.10%</td>
</tr>
<tr>
<td>addiction</td>
<td>1.10%</td>
<td>1.10%</td>
</tr>
</tbody>
</table>

C = Caucasian, FN = First Nations
Study comparisons. According to the data provided from the Burnaby researchers, 100% of the youths in the Burnaby study were either socially using, abusing, or addicted to alcohol. Of those, 14.1% sexually offended while under the influence of alcohol, with 54.5% of those being of First Nations ancestry, compared to 18.2% Caucasian and 27.3% other ethnicities. In addition, 92.4% of the youths in the Burnaby study either socially used or abused substances.

The analysis showed a significant difference between the Burnaby and Northern studies in respect to alcohol use by the clients, $\chi^2 (1, N = 159) = 16.174, p = 0.000, (r = .32)$, with Burnaby youths showing a higher rate of addiction to alcohol than northern youths. There was also a significant difference between the studies in respect to drug use, $\chi^2 (1, N = 159) = 15.413, p = .000, (r = .31)$, with a higher rate of substance abuse recorded on the Burnaby files. A comparison of the scores for alcohol and drug use based on the two primary ethnic groups for the combined studies revealed no significant differences between Caucasian and First Nation cases for alcohol use, ($\chi^2 (1, N = 143) = 2.97, p = .085$), or drug use, ($\chi^2 (1, N = 138) = 1.970, p = .160$).

Mental Health and Diagnoses

Northern study. Information collected from the files revealed that 12.9% of the northern cases had a history of attempted suicide, and 5.4% had a history of intentional self-harming behaviours (i.e. cutting or self-mutilation). Attention Deficit Hyperactivity Disorder (ADHD) was diagnosed in 32.3% of the northern cases and 10.8% of the cases had a diagnosis of Conduct Disorder (Table 11, p.149). The file histories also revealed that
36.6% of the youths had been exposed to alcohol in utero with 6.5% of the cases being formally diagnosed with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE).

Intake data showed 4.3% of the cases had a diagnosed mental illness prior to their referral to YFPS. Of the 34 cases with a discharge DSM diagnosis, 19 cases had more than two diagnoses. The most frequently occurring diagnosis was for the sexual or physical abuse of a child, at 44.12%, referencing the sexual offense resulting in the referral to YFPS.

Learning and academic performance disorders (DSM codes 315.xx) were diagnosed in 16% of the cases, and ADHD related disorders were the third most commonly

Table 11

Mental Health and Diagnoses

<table>
<thead>
<tr>
<th></th>
<th>Northern study</th>
<th>Burnaby study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of</td>
<td>% of</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>6.50%</td>
<td>9.80%</td>
</tr>
<tr>
<td>FN</td>
<td>6.50%</td>
<td>6.50%</td>
</tr>
<tr>
<td>Suicide attempt/s</td>
<td>12.90%</td>
<td>15.70%</td>
</tr>
<tr>
<td>C</td>
<td>6.50%</td>
<td>9.80%</td>
</tr>
<tr>
<td>FN</td>
<td>6.50%</td>
<td>6.50%</td>
</tr>
<tr>
<td>Self-harming behaviours</td>
<td>5.40%</td>
<td>4.30%</td>
</tr>
<tr>
<td>C</td>
<td>3.30%</td>
<td>3.30%</td>
</tr>
<tr>
<td>FN</td>
<td>2.20%</td>
<td>4.30%</td>
</tr>
<tr>
<td>ADHD Diagnosis</td>
<td>32.30%</td>
<td>5.60%</td>
</tr>
<tr>
<td>C</td>
<td>17.20%</td>
<td>14.90%</td>
</tr>
<tr>
<td>FN</td>
<td>14.00%</td>
<td>4.30%</td>
</tr>
<tr>
<td>Conduct Disorder Diagnosis</td>
<td>10.80%</td>
<td>20.20%</td>
</tr>
<tr>
<td>C</td>
<td>6.50%</td>
<td>6.50%</td>
</tr>
<tr>
<td>FN</td>
<td>4.30%</td>
<td>56.20%</td>
</tr>
</tbody>
</table>

FAS/FAE

- No prenatal alcohol exposure 57.00% 37.60% 19.40% 72.00% 47.60% 2.40%
- Exposed to alcohol in utero 36.60% 16.10% 20.40% 18.30% 7.30% 6.10%
- Diagnosis of FAS or FAE 6.50% 2.20% 3.20% 9.80% 2.40% 6.10%

Note: C = Caucasian; FN = First Nations
represented, with 30 cases (31.52%) having file information indicating a prior diagnosis of ADHD. Fifteen cases (14.5%) received that diagnosis from a YFPS assessment. There was no significant difference found between ethnic groups for DSM diagnoses received. Table 12 shows the more frequently assigned DSM codes from the northern sample.

### Table 12

**Most Frequently Occurring Mental Health Diagnoses (%) in Northern Study**

<table>
<thead>
<tr>
<th>DSM Code</th>
<th>All</th>
<th>Caucasians</th>
<th>First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.xx</td>
<td>15.79</td>
<td>17.65</td>
<td>14.29</td>
</tr>
<tr>
<td>V61.21</td>
<td>15.79</td>
<td>19.61</td>
<td>11.90</td>
</tr>
<tr>
<td>313.81</td>
<td>7.37</td>
<td>9.80</td>
<td>4.76</td>
</tr>
<tr>
<td>312.xx</td>
<td>5.26</td>
<td>3.92</td>
<td>7.14</td>
</tr>
<tr>
<td>315.10</td>
<td>5.26</td>
<td>5.88</td>
<td>4.76</td>
</tr>
<tr>
<td>315.20</td>
<td>4.21</td>
<td>3.92</td>
<td>4.76</td>
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<tr>
<td>302.90</td>
<td>4.21</td>
<td>3.92</td>
<td>4.76</td>
</tr>
<tr>
<td>302.20</td>
<td>3.16</td>
<td>3.92</td>
<td>2.38</td>
</tr>
<tr>
<td>V61.20</td>
<td>3.16</td>
<td>3.92</td>
<td>2.38</td>
</tr>
<tr>
<td>315.00</td>
<td>3.16</td>
<td>3.92</td>
<td>2.38</td>
</tr>
<tr>
<td>317.00</td>
<td>3.16</td>
<td>3.92</td>
<td>2.38</td>
</tr>
</tbody>
</table>

**Burnaby study.** A diagnosis of ADHD was present in 57.8% of the Burnaby cases, and 56.2% had a diagnosis of Conduct Disorder on record. In the Burnaby study, 15.7% of the cases indicated a prior suicide attempt, and 15.5% had a history of self-harming...
behaviours. Fifteen of the case histories showed fetal exposure to alcohol (18.3%), with eight cases (9.8%) having a formal diagnosis of FAS or FAE.

**Study comparisons.** A chi-square analysis revealed no significant difference between the Burnaby study and the Northern study in respect to history of suicide attempts, ($\chi^2(1, N = 195) = .306, p = .580$). However, a difference was found between the studies on the variable of self-harming behaviours, ($\chi^2(1, N = 186) = 14.269, p = .000, r = .28$), with the Burnaby study having a positive count of 24 cases (expected count 14.7) and the Northern study having a positive count of five (expected count 14.3).

For the diagnosis of FAS/FAE, the analysis revealed a difference ($\chi^2(2, N = 175) = 7.312, p = .026, r = .20$). In the Burnaby study, 15 youths (18.3%) were exposed to alcohol in utero, and eight (9.8%) were diagnosed with FAS. In the Northern study, 34 cases (36.6%) were exposed to alcohol in utero, and six (6.5%) were formally diagnosed with FAS. Significant differences between the studies were obtained for diagnoses of ADHD, ($\chi^2(2, N = 183) = 13.62, p = .001, r = .27$), and for conduct disorder, ($\chi^2(1, N = 182) = 42.47, p = .000, r = .48$). The Burnaby study had 52 cases (57.8%) with an ADHD diagnosis, and 50 cases (56.2%) with a diagnosis of conduct disorder, compared to 30 cases (32.3%) of ADHD in the Northern study, and 10 cases (10.8%) of conduct disorder.

**Victim Profile**

**Victim Gender and Age**

**Northern study.** The 95 cases in the Northern study had 154 identified direct sexual offense victims ($M = 1.62$). The victims ranged in age from 1 to 43 years old ($N = 149, M = 9.48, SD = 7.25$). Five year old children were the most common victims in the Northern
study (11.84%), followed by six year olds (11.18%), seven and nine year olds (9.87% each), then four and eight year olds (8.55% each). Of the cases in this study whose files included victim gender information \( n = 94 \), 61 (64.89%) offended only females, 21 (22.34%) offended only males, and 12 (12.76%) offended both males and females.

Examining the data based on ethnicity of the offender, the 52 Caucasian youths had 80 victims \( (M = 1.53) \) and the 42 First Nation youths had 72 victims \( (M = 1.71) \). Analysis of victim gender revealed more female victims \( (n = 101) \) than male victims \( (n = 53) \) with no significant difference between the two primary ethnic groups based on gender of victim \( (\chi^2 (1, N = 147) = .123, p = .726) \).

**Burnaby study.** There were over 131 victims represented in the victim categories of the Burnaby study \( (M = 1.18) \). The victims ranged in age from two to 50 years \( (N = 102; M = 8.62, SD = 7.15) \). Of those cases which included victim demographics, 71 (66.4%) of the youths offended against female victims, 22 (20.6%) offended against male victims, 12 (11.2%) offended against victims of both genders, and 2 (1.9%) of the youths’ victims were non-human. Victim gender analysis found no significant difference between ethnic groups in relation to victim gender, \( (\chi^2 (6, N = 107) = 7.723, p = .259) \).

**Study comparison.** Comparison of the studies found no significant difference between the studies based on victim gender, \( (\chi^2 (3, N = 201) = 2.061, p = .560) \) with a significant difference on ages \( (\chi^2 (4, N = 192) = 11.27, p = .024) \).

**Multiple Victims**

**Northern study.** As shown in Table 13, over a third of the cases in the Northern study had more than one identified victim: 38.95% had two victims, 11.58% had three
victims, 4.21% had four victims, 3.16% had five victims, and 1.05% had a sixth and seventh victim ($N = 1$). These numbers reflect both those victims for which the youth was charged on index offense, and those that were brought to the attention of the RCMP while the youth was in treatment: either as a result of admissions by the youth, or as a result of disclosures by additional victims.

An analysis of variance was used to compare the number of victims based on ethnicity of the offender. No significant difference between the two primary ethnic groups in respect to number of victims was found, $F (1, 91) = .397, p = .530$. Table 13 includes the descriptive information for the victims, organized according to ethnicity of the offender, noting the number of victims and victim ages.

*Burnaby study.* Of the 103 cases with victim number information, 77.7% had one victim, 20.4% had more than one victim, 1% had a non-person victim, and 1% were unspecified. In respect to the two primary ethnic groups, the 56 Caucasian offenders had a minimum of 68 victims, while the 24 First Nation offenders had a minimum of 27 victims. There was no significant difference in the number of victims based on ethnicity of the offender ($\chi^2 (3, N = 103) = 1.115, p = .773$).

*Study comparison.* A chi-square analysis revealed there was a significant difference between the two studies in respect to the number of victims, ($\chi^2 (1, N = 196) = 8.584, p = .003, r = .21$). In respect to the ages of the victims, six to 11 year olds were the most represented ages in the victim groups for both Caucasian (68.4%) and First Nation (46%) offenders, followed by 12 to 18 year olds: 15.8% for Caucasians and 31.7% for First Nations.
The third most represented victim age group for First Nation youths was 60 years and older (11.1%) while for Caucasians the remaining three age categories of zero to 5, 19 to 60, and over 60 years, each held 5.3% of the victim population. Because some categories held less than 5 cases, a Kruskall-Wallis analysis was conducted. Based on ethnicity, the differences in victim ages were significant, $\chi^2(1, N = 158) = 8.758, p = .003, r = .24$.

**Victim Relation to Offender**

*Northern study.* Initial examination of the victims' relation to their offender revealed that for offenders of both First Nation and Caucasian ancestries, friends and acquaintances were the most frequently selected victims (44.52%) (see Table 14). However, when individual family relationships were totalled, family members formed the largest victim group (49.03%). Family members included siblings, the largest family victim group (29.68%), followed by cousins (15.48%), nieces and nephews (2.58%), and caregiver or parents (1.29%). Sexual assaults against strangers were committed by 5.16% of the youths.

Figure 2 shows a graph of the victims in each category for the First Nation and Caucasian offenders in the Northern study. Data analysis revealed no significant differences between the two ethnic groups in respect to relation to victim, ($\chi^2(8, N = 147) = 6.949, p = .542$).
### Table 13

**Victim Description for Northern Study**

<table>
<thead>
<tr>
<th>Ethnicity of offender</th>
<th>Number of offenders</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Number of offenders</td>
<td>60</td>
<td>25</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>( M ) victim age (yrs)</td>
<td>9.64</td>
<td>10.26</td>
<td>10.36</td>
<td>8.71</td>
<td>8.64</td>
<td>13.75</td>
<td>13.75</td>
</tr>
<tr>
<td></td>
<td>Min. victim age</td>
<td>1.67</td>
<td>1.00</td>
<td>5.92</td>
<td>6.00</td>
<td>4.67</td>
<td>13.75</td>
<td>13.75</td>
</tr>
<tr>
<td></td>
<td>Max. victim age</td>
<td>43.00</td>
<td>32.00</td>
<td>15.00</td>
<td>13.25</td>
<td>13.25</td>
<td>13.75</td>
<td>13.75</td>
</tr>
<tr>
<td></td>
<td>( SD )</td>
<td>8.28</td>
<td>5.95</td>
<td>3.06</td>
<td>3.29</td>
<td>4.33</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Skewness</td>
<td>2.61</td>
<td>2.18</td>
<td>0.03</td>
<td>1.20</td>
<td>0.65</td>
<td>-</td>
<td>-</td>
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<tr>
<td></td>
<td>Kurtosis</td>
<td>7.27</td>
<td>6.27</td>
<td>-1.03</td>
<td>0.64</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Caucasian</td>
<td>Number of offenders</td>
<td>36</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>( M ) victim age (yrs)</td>
<td>8.01</td>
<td>13.07</td>
<td>13.02</td>
<td>13.25</td>
<td>13.25</td>
<td>13.75</td>
<td>5.00</td>
</tr>
<tr>
<td></td>
<td>Mdn victim age</td>
<td>7.00</td>
<td>9.25</td>
<td>13.54</td>
<td>13.25</td>
<td>13.25</td>
<td>13.75</td>
<td>5.00</td>
</tr>
<tr>
<td></td>
<td>( SD )</td>
<td>6.05</td>
<td>14.22</td>
<td>2.16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>First Nations</td>
<td>Number of offenders</td>
<td>24</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>( M ) victim age(yrs)</td>
<td>12.08</td>
<td>8.68</td>
<td>9.40</td>
<td>6.58</td>
<td>8.00</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Mdn victim age</td>
<td>9.00</td>
<td>7.00</td>
<td>9.00</td>
<td>6.58</td>
<td>8.00</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>( SD )</td>
<td>1.60</td>
<td>1.18</td>
<td>1.12</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Table 14

*Victim’s Relationship to Their Offender by Category (%) in Northern Study*

<table>
<thead>
<tr>
<th>Ethnicity of Offender</th>
<th>Category</th>
<th>Victims</th>
<th>%</th>
<th>Victims</th>
<th>%</th>
<th>Victims</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Friend/Acquaintance</td>
<td>69</td>
<td>44.52</td>
<td>35</td>
<td>43.75</td>
<td>34</td>
<td>46.58</td>
</tr>
<tr>
<td>FN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings (all types)</td>
<td></td>
<td>46</td>
<td>29.68</td>
<td>25</td>
<td>31.25</td>
<td>21</td>
<td>28.77</td>
</tr>
<tr>
<td>FN</td>
<td>Step-sibling</td>
<td>23</td>
<td>14.84</td>
<td>10</td>
<td>12.50</td>
<td>13</td>
<td>17.81</td>
</tr>
<tr>
<td>FN</td>
<td>Sibling</td>
<td>22</td>
<td>14.19</td>
<td>14</td>
<td>17.50</td>
<td>8</td>
<td>10.96</td>
</tr>
<tr>
<td>FN</td>
<td>Foster Sibling</td>
<td>1</td>
<td>0.65</td>
<td>1</td>
<td>1.25</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>FN</td>
<td>Cousin</td>
<td>24</td>
<td>15.48</td>
<td>14</td>
<td>17.50</td>
<td>10</td>
<td>13.70</td>
</tr>
<tr>
<td>FN</td>
<td>Stranger</td>
<td>8</td>
<td>5.16</td>
<td>2</td>
<td>2.50</td>
<td>4</td>
<td>5.48</td>
</tr>
<tr>
<td>FN</td>
<td>Niece/Nephew</td>
<td>4</td>
<td>2.58</td>
<td>3</td>
<td>3.75</td>
<td>1</td>
<td>1.37</td>
</tr>
<tr>
<td>FN</td>
<td>Caregiver/Parent</td>
<td>2</td>
<td>1.29</td>
<td>1</td>
<td>1.25</td>
<td>1</td>
<td>1.37</td>
</tr>
<tr>
<td>FN</td>
<td>Unknown</td>
<td>2</td>
<td>1.29</td>
<td>0</td>
<td>0.00</td>
<td>2</td>
<td>2.74</td>
</tr>
<tr>
<td>FN</td>
<td>Total</td>
<td>155</td>
<td>100</td>
<td>80</td>
<td>100</td>
<td>73</td>
<td>100</td>
</tr>
</tbody>
</table>

*Burnaby study.* Of the 101 valid cases, 46 (45.5%) offended against a family member, 39 (38.6%) offended against a friend or acquaintance, and 15 (15.8%) offended against a stranger. The Burnaby data did not differentiate between types of family members so I was unable to determine how many of the offenses were against bio-siblings, step-siblings, or cousins. In analysis of the categorized data, there was no significant difference...
between the primary ethnic groups in respect to the offender’s relationship to their victim,
\( \chi^2 (4, N = 101) = 6.732, p = .151 \).

![Victim's Relation Compared by Ethnicity of Offender - Northern Study](image)

Figure 2. Victim’s relationship to their offender – Northern study.

**Study comparison.** In comparing the victim-offender relationships in the two studies, a significant difference was found between the cases in the Burnaby study and those in the Northern study, \( \chi^2 (2, N = 194) = 7.302, p = .026, r = .19 \). The largest
difference was in the number of cases in which the victim was a stranger: 15.8% of Burnaby’s cases compared to 4.3% of those in the North.

Offense Information

Criminal Histories

Northern study. Of those files with criminal history information available (n = 94), 43.6% of the cases had a history of involvement with police prior to the index offense. Of all cases in the Northern study, 42.6% had committed a prior criminal offense, with 3.2% having committed a prior sexual offense before the commission of the index offense resulting in the referral to YFPS. There were no significant differences found between the two primary ethnic groups on the variables of prior police involvement, prior criminal offenses, or prior sexual offenses.

Burnaby study. Sixty-nine of 110 youths (62.7%) in the Burnaby study had contact with the police prior to the offense for which they were referred to YFPS. There was no significant difference between the ethnic groups in respect to prior RCMP contact, $\chi^2 (2, N = 110) = 1.268, p = .530$. Examination of the Burnaby data also revealed that 66.7% of the youths in their study had committed prior non-violent offenses, 42.4% had committed prior violent offenses, and 17.8% had committed a prior sexual offense. Researchers in the Burnaby study did not code the specific violation of the Canada Criminal Code, so that information is unavailable for presentation in this paper.

Study comparison. Chi-square analysis revealed some differences between the cases in the two studies in respect to: prior police involvement, $\chi^2 (1, N = 204) = 7.450, p =$
Youth who sexually offend

.006, \( r = .19 \); prior criminal offenses, \( \chi^2 (1, N = 203) = 9.545, p = .002, r = .22 \); and prior sexual offenses, \( \chi^2 (1, N = 197) = 4.310, p = .038, r = .15 \).

Index Offense Location

Northern study. As shown in Figure 3, the offense locations in the Northern study were coded into one of six categories to better define the location of the index offense. This coding format revealed that more offenses occurred in homes where the victim and offending adolescent resided together (27.74%) than occurred in public areas (13%). However, offenses that took place in the offender’s home (20.65%), the victim’s home (19.35%), or their shared home (27.74%) represented a combined total of 67.74% of all the offenses. There was no significant difference found between the primary ethnic groups for offense location (\( \chi^2 (6, N = 153) = 8.315, p = .216 \)).

Burnaby study. Researchers in the Burnaby study coded the location of the index offense into one of three categories: home, school/work, or public. Their data on 103 cases shows that 78.6% of the offenses occurred in a home, 17.5% in a public place, and 3.9% in schools or at work. Most offenses were committed in a home: Caucasian youths committed 84.2% and First Nation youths committed 80% of their offenses in a home. First Nation youths did not commit any of their offenses in a school or work setting; the 3.9% of the total offenses committed at school or work, were committed by Caucasian youths or youths of another ethnicity.
Study comparison. Analysis of the combined studies revealed 82.1% of all offenses took place in a home, 14.4% in public, and 3.6% in a school or work setting. When the data on offense location from the Northern study was recoded to match the categories used in the Burnaby study, analysis revealed there were no significant differences between the studies in respect to where the offenses took place, $\chi^2 (2, N = 195) = 1.839, p = .399$.

There was also no significant difference between the two primary ethnic groups on offense location, $\chi^2 (2, N = 159) = 1.787, p = 409$. 

Figure 3. Offense locations in the Northern study.
Offense Specifics

Northern study. In total, the youths in the Northern study committed 194 violations of the Criminal Code of Canada when they sexually offended. The majority of youths were charged with one offense (56.38%); of the remaining, 17.02% were charged with two offenses; 8.51% for both three and four offenses; 3.19% with five offenses; 4.26% with six offenses; and 2.13% of the youths were charged with seven offenses of the Criminal Code. No significant difference was found on number of charges based on ethnicity, \( \chi^2 (6, N = 94) = 5.675, p = .461 \). The 194 violations were in one of 19 separate sections of the Criminal Code of Canada. The data is presented in Table 15 in order of most frequent violations, with frequencies and percentages of each violation also shown for the two primary ethnicities. No significant differences were found between the primary ethnic groups for offense type, \( \chi^2 (19, N = 196) = 23.283, p = .225 \).

Examination of the offense details showed 25% of the sexual offenses took place when the offender was babysitting, and 19.6% of the sexual offenses involved the offender threatening the victim. Specifics of the index sexual offenses revealed that 13 youth were, or claimed to be, under the influence of alcohol (9.6%) or substances (4.3%) at the time they committed their offense(s). When analyzed based on ethnicity of the offender, a significant difference was found for commission of the offense under the influence of alcohol (\( \chi^2 (1, N = 93) = 8.027, p = .005 \)), with more First Nations than Caucasians being under the influence of alcohol at the time of offense. There was no differences between the ethnic groups for commission of the offense under the influence of substances (\( \chi^2 (1, N = 93) = 8.027, p = .809 \)). In addition to the sexual offenses, some of the youths committed
other violations of the Criminal Code related to their sexual offending, as shown in Table 16.

Table 15

Sexual Offenses

<table>
<thead>
<tr>
<th>Criminal Code of Canada Offense</th>
<th>All</th>
<th>%</th>
<th>Caucasian</th>
<th>%</th>
<th>First Nation</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 271 - Sexual assault</td>
<td>115</td>
<td>59.28</td>
<td>63</td>
<td>59.43</td>
<td>51</td>
<td>58.62</td>
</tr>
<tr>
<td>Section 151 - Sexual interference</td>
<td>28</td>
<td>14.43</td>
<td>15</td>
<td>14.15</td>
<td>13</td>
<td>14.94</td>
</tr>
<tr>
<td>Section 152 - Invitation to sexual touching</td>
<td>16</td>
<td>8.25</td>
<td>12</td>
<td>11.32</td>
<td>4</td>
<td>4.60</td>
</tr>
<tr>
<td>Section 159 - Anal intercourse</td>
<td>6</td>
<td>3.09</td>
<td>5</td>
<td>4.72</td>
<td>1</td>
<td>1.15</td>
</tr>
<tr>
<td>Section 155 - Incest</td>
<td>5</td>
<td>2.58</td>
<td>4</td>
<td>3.77</td>
<td>1</td>
<td>1.15</td>
</tr>
<tr>
<td>Section 266 - Assault</td>
<td>3</td>
<td>1.55</td>
<td>1</td>
<td>0.94</td>
<td>2</td>
<td>2.30</td>
</tr>
<tr>
<td>Section 272 - Sexual assault with a weapon, threats to 3rd party, or causing bodily harm</td>
<td>2</td>
<td>1.03</td>
<td>1</td>
<td>0.94</td>
<td>1</td>
<td>1.15</td>
</tr>
<tr>
<td>Section 153.1 - Sexual exploitation of a person with a disability</td>
<td>1</td>
<td>0.52</td>
<td>1</td>
<td>0.94</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Section 173 - Indecent acts</td>
<td>1</td>
<td>0.52</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
<td>1.15</td>
</tr>
<tr>
<td>Section 273 - Aggravated sexual assault</td>
<td>1</td>
<td>0.52</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
<td>1.15</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>194</td>
<td>100%</td>
<td>106</td>
<td>100%</td>
<td>87</td>
<td>100%</td>
</tr>
</tbody>
</table>

_Burnaby study_. The information from the Burnaby study showed that 27.3% of the youths sexually offended while babysitting and threats were used by 36.8% of the youths.
Committing a sexual offense while under the influence of alcohol occurred for 14.1% of the Burnaby cases. However, 54.5% of those were First Nation youths, compared to 18.2% Caucasian and 27.3% other ethnicities. Identification of cases where the youth was under the influence of drugs at the time of the commission of the sexual offense was not available.

Study comparison. Chi-square analysis revealed no significant difference between the two groups in respect to the number of offenses which took place when the youth was babysitting, \( \chi^2 (1, N = 191) = .127, p = .721 \). Examination of threats used in the commission of the sexual offenses revealed a difference, \( \chi^2 (1, N = 179) = 6.584, p = .01, r = .19 \).

In the Burnaby study, of the 14.1% under the influence of alcohol at the time of their sexual offense, 18.2% were Caucasian, and 54.5% were First Nations. In the Northern study, of the 9.6% under the influence of alcohol, 11.1% were Caucasian and 88.9% were First Nations. There was no significant difference found between the two studies in regards to committing the offense while under the influence of alcohol, \( \chi^2 (1, N = 172) = .851, p = .356 \). However, analysis of that variable in respect to the ethnicity of the offender revealed a significant difference, \( \chi^2 (1, N = 143) = 15.704, p = .000, (r = .33) \), with First Nation youths committing 82.4% of the offenses which took place while under the influence of alcohol.
## Table 16

**Nonsexual Offenses**

<table>
<thead>
<tr>
<th>Criminal Code of Canada Offense</th>
<th>All</th>
<th>Caucasian</th>
<th>First Nations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sec. 279 - Kidnapping</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sec. 348.1 - Home invasion</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Sec. 266 - Assault</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sec. 810 - Fear of injury or damage to property</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sec. 172 - Corrupting morals of a child</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Sec. 264 - Criminal harassment</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
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CHAPTER FIVE
Discussion

Introduction

For the purpose of highlighting similarities and differences between the samples, in this chapter I summarize the findings from the Northern study on each of the study variables in comparison to findings both from the literature and from the Burnaby study, and discuss the implications of those comparisons. The first section, Client Demographics includes ethnicity, gender, age, and access to service. Client Characteristics, the second section, includes: intellectual functioning, school performance, drug and alcohol use, mental health, fetal alcohol syndrome and exposure to alcohol in utero, criminal histories, and number of victims. In the third section, Victim Profile, I discuss victim gender, victim age, and relation to the offender. Next, in the section titled Characteristics of the Index Offense, I discuss the index offense location and the specifics of the offenses. Finally, I provide my conclusions and recommendations in the final two sections of this chapter.

Client Demographics

Ethnicity

The ethnic representation of the participants of the Northern study differed from the ethnic representations of similar studies I reviewed in the literature. Many of the studies in the literature were drawn from urban populations with a greater representation of Black or Hispanic youths, neither of which were represented in the Northern study. In agreement with Moore’s (2003) findings, there was an over-representation of aboriginal youths in
comparison to the distribution of aboriginals in the federal population. Even with aboriginal representation in Northern British Columbia at close to 25% (BC Stats, 2001), much higher than the national average of 8% (Moore, 2003), a comparison of the number of youths of First Nations ancestry to the number of Caucasians in this study echoes a significant overrepresentation of First Nations people: 44% of the cases in the study were of First Nations ancestry. The Burnaby study had an ethnic compilation which better reflected similar studies in the literature, with representation from Caucasian, Asian, First Nations, East Indian, Latino and mixed ethnicities, whereas the cases in the Northern study were comprised of approximately 55% Caucasian and 44% First Nations, with 1% of unspecified ethnicity.

During recent years, the Government of British Columbia has invested in advertising and training its employees on the need for cultural sensitivity in their work with the public. However, the distinct ethnic composition of the Northern study reveals more than a need for cultural sensitivity; the significant representation of First Nation people identifies the importance of clinicians having a solid understanding of the issues affecting almost half of their client population, as well as a skill set of interventions which can complement those of First Nation cultures while maintaining empirical validity.

The findings of ethnic representation in this study also raise questions about the reasons for the lack of ethnic diversity in the study, despite the sample being taken from a clinic which services a geographical area which includes people of other ethnicities, such as Asian and East Indian. Further research may reveal an explanation for this observation: other ethnic groups may not be experiencing incidences of sexual abuse as frequently as the Caucasians and First Nation families; the frequency of abuse in other ethnicities may be
similar but the incidences are either not being reported, or not being processed in the judicial system; or youths of the other ethnicities are not being referred by the courts for assessment or treatment at YFPS.

Gender and Age

In agreement with studies released by the Correctional Service of Canada (2003), the majority of youths charged with sexual offenses in the Northern sample were male (97.9%), with only two females represented (2.1%). All youths in the Burnaby study were male. There was no indication that females had been in their initial sample and excluded for any reason. There is consistent agreement in the literature that the vast majority of persons before the courts for sexual offending behaviour are male. However, there is increasing awareness of the incidences in which females commit sexual offenses (Denov, 2003; Higgs, Canavan & Meyer, 1992; Lowenstein, 2006). The reason for the underrepresentation of females in the literature cannot be fully explained at this time, however, I speculate that offenses by females are not reported as often for several reasons. First, there is the likelihood of victim confusion over inappropriate touching by a female when the offense takes place while receiving assistance in physical care, such as bathing or dressing. Also, it may be difficult for males to report being the victim of sexual abuse by a female in a society where the media portrays a characteristic of masculinity to be the pursuit of sexual encounters with females; to voice objection to such an encounter could risk taunting by peers.

In addition, the media’s typical portrayal of sexual offenders as males may be a factor; it is common knowledge that males commit sexual offenses. The lack of
information about female perpetrators may affect disclosures of victimization by a female sexual offender. The number of females found in the Northern study (2) was insufficient for data analysis, however, with the increasing awareness of females committing sexual offenses, future studies may be able to draw meaningful comparisons to better identify the characteristics of female adolescent perpetrators.

In respect to the age at which they committed their index offense, the mean age of the youths in the Burnaby sample (15 years) was slightly higher than the mean age of the youths in the Northern sample (14.42). Ryan et al. (1996) reported that the majority of sex offenders commit their first offense before the age of 15, and Latimer et al. (2003) stated that the average age of adolescent sexual offenders in the literature is 15.23 years. Fortune and Lambie (2004) found that youths were 15 or 16 years of age by the time they were referred to services for sexual offending behaviour. The findings of this study concur with the literature, with the average age at time of offense being 14.42 years, and their mean age being 15.83 years at the time of their involvement with YFPS.

Although the difference was statistically insignificant, the slight difference of mean ages at the time of first offense between the Burnaby and Northern studies may be a reflection of the difference found on the variable of prior sexual offenses; less than 4% of the Northern sample had a prior sexual offense, whereas over 17% of the youths in the Burnaby sample had committed a prior sexual offense. Given their lower mean age at time of index offense, coupled with their lower rate of prior sexual offenses, I speculate that youths in northern British Columbia are being judicially processed and referred to YFPS' northern clinic after their first sexual offense charge more often than youths being referred to the Burnaby YFPS clinic.
While the youth sexual offenders in Northern British Columbia were before the courts on their first sexual offense charge more often than their Burnaby counterparts, the time lapsed from the date of the offense to the date of being judicially processed was significantly different between the two groups. The average length of time from index offense to referral to the northern YFPS clinic was 16.92 months, compared to a time lapse of 8.64 months for youths in the Burnaby study. Youths in the metropolitan area of the province are before the courts and referred for assessment or treatment in almost half the time as youths in Northern British Columbia.

Notwithstanding the reason for the delay in Northern British Columbia, the length of time that passes between the offense and the time of accountability and intervention is a concern for several reasons. The first reason is the potentially negative affect the delay can have on the outcome for the youth’s treatment. A long delay between the time of the offense and the time of intervention has the potential to provide the youth with an avenue to avoid accepting responsibility by claiming that the offense occurred so long ago that he is, therefore, unable to recall some of the details of his actions, thereby negatively affecting the youth’s assessment and treatment.

Another concern with the delay is the effect on the victim and the victim’s family. Once the disclosure has been made, the investigation is completed, and the offending youth has been charged with the sexual offense, the time spent waiting for the court process to complete and for interventions to take place with the youth can be particularly stressful for the victim. Due to the fact that sexual abuse counsellors are unable to openly discuss the offense with the victim until the court process is completed for risk of being accused of tampering with evidence by discussing the victim’s experience, the victim’s ability to
receive effective assistance is also hindered and the victim is, in essence, being re-
victimized by the delay. A third concern is that, until processed by the courts and placed on
a probation order with conditions restricting his freedoms in the community, the youth is
not likely to be effectively supervised to prevent access to other potential victims.
Consequently, the risk is higher for further offenses which again may not be promptly, or
ever, reported to the authorities.

Yet another concern regarding a long delay between the time of offense and the
imposition of probation conditions is the impact the delay may have on the offender’s
family’s ability to understand the seriousness of the situation. Families of youths before the
court a year or more after the offenses took place have often expressed to me their
frustration in trying to understand why their sons received a probation order that prohibits
him from being around children under the age of 14 years, which may include his siblings,
when the offense took place so long ago. The family’s frustration in understanding the
supervision changes after a long delay may increase the likelihood that they will not report
violations of the youth’s probation conditions to the supervising officer, effectively
undermining the authority of the court and treatment effectiveness and, again, potentially
increasing the risk of the youth offending more victims. Due to the risk for this delay to
negatively impact both the victim and the offender in several ways, the reason for the
differences in time lapsed between the index offenses and the referrals to YFPS warrants
further research.

The service files in the Burnaby clinic remained open slightly longer than those in
the North. The longer service lengths, particularly for assessment files, is attributed to the
use of the file closure date on the computer tracking system to determine end of service; it
is suspected that caseload demands resulted in file closures and computer data entry receiving low priority, thereby skewing service duration measurements. Calculation of the number of hours the youths spent in direct contact with their clinicians would have been an more accurate determinant of length of service. That data may also have provided more valuable information for future studies regarding treatment effectiveness and recidivism rates.

Access to Services

In agreement with the information of the National Clearinghouse on Family Violence (2002), the findings of this study show that access to specialized youth sexual offender treatment in rural northern areas is severely limited. The distances travelled by youths and their families to reach the Northern YFPS clinic provide evidence of the lack of specialized sexual offender treatment services in Northern British Columbia. Given the differences in geographical areas serviced by the Burnaby and Prince George clinics respectively, it was not a surprise that clients were not required to travel as far to access services at the Burnaby clinic, whose radius of service is approximately 35 kilometres, compared to that of the Prince George clinic whose area reaches over 800 kilometres to the north, and over 700 kilometres to the west.

The data collected in this study indicates that 15 of the 92 clients (16%) had to travel over 500 kilometres one-way to access primary assessment and treatment services at the northern YFPS clinic. Of those clients who travelled over 500 kilometres, 87% were of First Nations ancestry: 31% of all the First Nation clients compared to only 4% of the Caucasian clients. The vast disparity in travelled distances between the two primary ethnic groups is alarming, although I speculate that the data is capturing the ethnographic
composition of the northern areas of the province, where many small First Nation communities are situated in remote regions, far from the more Caucasian-populated centres.

The problem of providing easily-accessed services to the small First Nation communities in northern British Columbia is not easy to overcome. In addition to the high cost factors of establishing primary assessment and treatment clinics in each of the northern communities, there are the additional complications of acquiring and retaining sufficiently trained clinicians to staff those clinics. To overcome these problems, the Northern YFPS clinic has contractors in many of the larger northern communities; contracted clinicians who have appropriate educational and experiential backgrounds provide individual counselling services to youths before and after they attend the primary treatment program in Prince George.

As mentioned previously, due to the lack of psychiatrists and psychologists in specializing in assessment and treatment of this population, YFPS regularly imports doctors from southwest British Columbia, each of whom takes leave from their practice in the metropolitan area in order to provide service in the Prince George clinic for one to three days a month. Due to their limited time availability, the doctors see clients in the clinic. This allows a doctor to see several youths in one day, rather than only one, as would be the case if the doctor travelled to the community. However, the travelling distances faced by many families may have a direct impact on the youth’s assessment in several ways.

First, due to the financial burden on the family from the combination of missing work hours plus travelling costs in order to reach the clinic for assessment, it is seldom that both parents are able to attend the clinic for the youth’s assessment. For the assessing
doctor on those cases, the distance between the clinic and the youths’ home community directly affects his or her ability to supplement collateral information by interviewing the parents or guardians in person. Second, meeting the family in their own community, or their own home, is an experience which some doctors have described as being very helpful during assessment because it provides them with a better understanding of the youth, his family, and their environment. This opportunity is negated when the distances and time factors are examined.

Third, again due to the distance and costs incurred in travelling, many families that cannot afford overnight accommodation and do not access financial assistance, chose to drive to the clinic the morning of the assessment, often leaving their home community at an hour when the youth would typically be sleeping. There are concerns that the disruption of sleep and routine can play a negative role in the outcome of psychometric testing results. The doctor’s inability to personally interview the parent/s and other caregivers, the assessor’s inability to see the youth’s home and community firsthand, the disruption of routine potentially affecting psychometric scores, and the issue of financial burden on the offenders’ family are all factors directly impacted by the distance between the client’s home and YFPS clinic. In light of the data collected in this study for this variable, these factors may be affecting over 50% of all the assessments conducted.

When the assessment indicates it is required, the assessing doctor will recommend the youth attend primary sexual offense treatment. When this study began, primary treatment for sexual offending behaviour at YFPS was also offered only in Prince George, dictated by cost and staff availability factors. Youths in Northern British Columbia referred for primary sexual offense-specific treatment at YFPS were required to reside in Prince
George to access the clinicians trained in providing primary treatment; for many youths, this meant residing over 200 kilometres from their homes. Parents from communities outside Prince George whose youths were required to attend for treatment were forced to find alternate living arrangements for their youth for the length of the treatment program. Some parents were relieved of the burden of finding accommodation for their youth because the court ordered that the youth had to reside in specialized housing in Prince George.

Whether organized by family or by the court, this arrangement of having the youth reside in Prince George to access primary treatment makes it difficult for the clinicians to work directly with the youth’s family, which many believe to be an important component for successful intervention. In addition, it restricts the family’s ability to meet regularly with the youth’s therapist. Instead, the contractor residing closest to the family’s community is relied on to engage the family in the intervention process.

Before the completion of this study, the Northern clinic began the process of expanding their primary treatment and counselling services to better serve outlying areas by placing a full time clinician trained in the provision of primary offense treatment in a community with a high rate of youth offenses. This expansion of service eliminated the need for youths charged with a sexual offense to relocate to access the service in Prince George when they do not require the external structured residence\footnote{Having the youth reside outside of the family home is sometimes necessary in order to facilitate treatment. The youth may need an external placement when the victim resides in the youth’s home or, for another example, when the youth must be supervised 24 hours a day and the family is unable to do so effectively.} to support treatment.

While this move is a positive step in the provision of counselling and treatment services to the smaller communities in the province, the data from this study clearly indicates the need for more clinicians to be trained to provide primary sexual offense
Youth who sexually offend 176

treatment, and for that treatment to be provided in the smaller communities to eliminate the separation of families and to facilitate interventions with the youth's family. Of particular benefit would be the ability to provide assessment services in the home communities in order that the assessing doctors can gain easier access to collateral sources firsthand, a move which is speculated to greatly increase family cooperation in the process by eliminating their significant cost and inconvenience factors. Unfortunately, the provision of this level of service would require not only the hiring and retention of more trained clinicians, but the support of communities and government to shoulder the resulting costs.

Client Characteristics

Intellectual Functioning

As mentioned previously in the literature review, Ferrara and McDonald (1996) had noted that one consistent finding in the literature is that assessments of delinquents often shows a performance IQ (PIQ) which is greater than their verbal IQ (VIQ). That finding was echoed in the data of this Northern study, which showed the youths' mean PIQ (87.45) at 4.92 points higher than their mean VIQ (82.53). The data from the Burnaby study also echoed Ferrara and McDonald's (1996) observation, with the mean PIQ (91.74) at 6.69 points higher than the mean VIQ (85.05). Nevertheless, there was no significant difference found between the Northern and Burnaby studies in respect to the FSIQ, PIQ or VIQ scores, nor was there a difference between the studies in regards to the number of cases meeting the criteria for a mental handicap diagnosis and access to supportive programs under Community Living Services12.

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12 Community Living Services (CLS) provides support to residents of British Columbia who are deemed to be mentally handicapped. CLS currently requires that the client have an FSIQ of 70 or less in order to qualify for

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Although the findings revealed there was no significant difference on FSIQ, PIQ, or VIQ between the Burnaby and Prince George samples, the data did indicate a significant difference between the primary ethnic groups in both studies on the variable of FSIQ when the cases from both studies were combined then re-examined based on ethnicity. The mean FSIQ of the YFPS clients of First Nations ancestry (78.93) was 9.58 points lower than the mean IQ of the Caucasian clients (88.51).

The marked difference in mean FSIQ scores could be attributed to a variety of factors. For example, the tests used to determine FSIQ were not normed on British Columbia’s youth of First Nations ancestry, bringing into question the validity of those subtests which are most sensitive to cultural influence: vocabulary, for instance. Other possible explanations include issues such as geographical isolation, financial limitations and cultural differences; the First Nations youths are unlikely to have had the benefit of the same developmental infant programs, educational preschool sessions, and home-learning technologies which would have put them on equal footing with Caucasian youths from the more populated communities. Another possible explanation is the number of First Nation youths exposed to alcohol in utero, as described below under Mental Health Diagnoses.

Given the number of possible factors influencing this finding, the significant difference in mean FSIQ between the two primary ethnic groups merits further research.

The literature did provide sufficient evidence, however, to effectively counter the myth that intellectually impaired youths commit more sexual offenses than non-mentally challenged adolescents. Prior research has shown that the rates of sexual offending behaviours are not predictable based on IQ scores and the perceived higher rate of offenses their support services. That requirement, based on the client’s IQ score, is being challenged and is currently under review by the Supreme Court of Canada.
by those with cognitive impairments is more likely attributed to the higher level of supervision they receive on a daily basis (Ashman & Duggan, 2003; Gilby et al., 1989; Holland et al., 2002; Tudiver et al., 2000).

**School Performance**

As noted in the literature, a majority of adolescents who commit sexual offenses have learning difficulties or demonstrate behavioural problems in school (Browne & Finkelhor, 1986; Foley, 2001; Kahn & Chambers, 1991; Knight & Prentky, 1993; O'Brien & Bera, 1986; Ryan et al., 1996; Shields, 2004), and more than half of them are in the 8th or 9th grade (Kahn & Chambers, 1991). The findings of this study concur with those findings in the literature: over 70% of the youths in the Northern study had a history of learning difficulties, 47.30% had a diagnosed learning disability, over 78% demonstrated problem behaviours at school, and 8.58 was their mean grade in school.

Similar to the findings in the Northern study, the Burnaby study showed 54.80% of the cases had a diagnosed learning disability, with a mean grade of 8.64. Both studies showed that approximately 40% of the cases attended alternate education programs. Examination of the combined data based on ethnicity showed that First Nation youths had more learning difficulties and more diagnoses of learning disabilities than the Caucasian youths. This observation may be directly linked to the proposed explanations for the finding that youths of First Nations ancestry showed lower overall intellectual functioning scores than the Caucasian youths, as noted above.

The findings from both the Burnaby and Northern studies support the literature in regards to the academic characteristics of sexually offending youths; the majority of the
Youths in this study had a history of behavioural problems in school (78.50%). Although some researchers have speculated that the youth's problem behaviours may be a reflection of other problems such as: developmental, adjustment, or self-esteem problems (Feherenbach et al., 1986); lack of social competency (Hudson & Ward, 2000); or neurological impairment (Ferrara & McDonald, 1996), the literature has yet to conclusively determine if the problem behaviours and learning disabilities contribute to, or are the result of, the reasons for the sexual offending behaviour. Further research into the detailed characteristics of the academic problems may explicate this repeated observation.

This study also supported the literature in respect to the frequency of learning problems in this population. Data from the Northern study revealed that 72% of the youths had difficulties in learning, with over 47% of the youths meeting the criteria for diagnosis of a learning disability. With such a high rate of the youths having a history of learning difficulties, this finding identifies some important factors for treatment clinicians to consider.

As identified by Langevin, Marentette and Rosati (1996), youths with learning disabilities are likely to have had prior negative experiences of being in group learning situations in school settings. Those self-esteem damaging experiences may negatively influence their willingness to effectively engage in group treatment programs. In addition, given the high rate of learning difficulties it can be expected that standardized program material is not being well understood by a majority of the youths. While some researchers have voiced the importance of employing treatment programs which compensate for the clients' deficiencies in learning ability (Ashman & Duggan, 2003; Duehn, 1994; Mann, 2004; Petersilia, 2000, Robinson & Rapport, 1999), others have shared their concern about
the lack of empirical studies on the efficacy of the programs (Brown & Kolko, 1998; Eastman, 2004; Worling & Curwen, 2000).

Until researchers conduct and publish the findings of more empirical studies on the treatment of youths with learning difficulties, the conclusions of Ashman and Duggan (2003), as noted in the literature review, remain true; due to the lack of randomized controlled trials on the evidence of effectiveness of treatment for sexual offenders with learning disabilities, clinicians working with youths with learning disabilities will remain unable to base their choice of intervention for treatment on empirical evidence. More studies on this topic are urgently needed.

In the meantime, clinicians working with youths with learning difficulties may want to keep in mind the high rate of learning difficulties, especially in the First Nations treatment population, and base their specific interventions on the psychometric testing results of each individual. For those doing group treatment, this may mean planning and adjusting group treatment programs to meet both the emotional and learning needs of the individual participants.

**Drug and Alcohol Use**

The majority of youths in the Northern study (61.9%) met the criteria for the social use or abuse of alcohol, with 58.7% meeting the criteria for the social use, abuse or addiction of substances. However, in support of the findings that offending under the influence of alcohol is uncommon (Davis and Leitenberg; 1987; Fehrenbach et al., 1986), and contrary to more recent findings suggesting that 40% to 50% of sex offenders reported they were under the influence of alcohol at the time of their offense (Kelley, et al., 2004;
Langevin, 2003; Lightfoot & Barbaree, 1993; Monson, et al., 1998), only 9.6% of the youths in the Northern study were under the influence of alcohol, and just over 4% were under the influence of non-prescribed substances at the time they sexually offended.

In respect to types of drugs used, the researchers in the Burnaby study coded substances based on the type of drugs used, not on the most frequently used as was done in the northern sample. The coding system of the Burnaby study resulted in the largest group of cases (27.27%) being placed into categories indicating that more than one type of substance was used, without clear differentiation on the specific substances of choice.

The data comparison of the Burnaby and Northern studies on the variables of alcohol use and drug use revealed a much higher rate of alcohol and drug use in the Burnaby study (100% and 92.4% respectively) than in the Prince George study (61.9% and 58.7% respectively). However, as with the Northern study, the Burnaby findings contradicted the conclusions of literature claiming that 40-50% of youths that commit sexual offences do so under the influence of alcohol: 14.1% of the youths in the Burnaby study were noted to have been under the influence of alcohol at the time they committed their sexual offense. Further, the results on alcohol use prior to offending were also in agreement between the studies in respect to ethnicity, with the majority of such offenses committed by youths of First Nations ancestry.

The high rate of commission of sexual offenses by First Nations youths under the influence of alcohol (82.4% of all such offenses) was of interest from a treatment perspective as the co-morbid issue of alcohol abuse and sexual offending behaviour would influence selected interventions, treatment plans and the individual’s relapse prevention strategies. However, the data from this study does not allow for conclusions to be drawn.
about the link between ethnicity and sexual offending behaviour after alcohol consumption. Further research into that finding may provide some insight.

Further research may also explain the differences between the YFPS studies and the literature in reference to the percentage of offenses committed after the consumption of alcohol. One possibility suggested twenty years ago by Davis and Leitenberg (1987), as noted in the literature review, is that many youth will claim to have been under the influence of alcohol at the time of their offense in order to avoid taking responsibility for the crime. Therefore, the low rate of these offenses in the YFPS studies may indicate these youths were more truthful during their assessments, and did not falsely claim to have been under the influence of alcohol when they committed their sexual offenses. Alternatively, unless specifically noted in the police report so that the assessor could confront the youth on the fact of alcohol influence, those youths who had been under the influence of alcohol may not have admitted that due to fear of additional consequences. Another possibility is differences between the studies in how researchers defined the term “under the influence at the time of offense.” New research which specifies the amount of alcohol consumed and the time lapse between consumption and offense may provide a more accurate picture of this dynamic of sexual offending behaviour.

Mental Health

According to the literature, mental health issues are frequent among sexual offenders; several studies found over 30% of study participants had a history of mental illness (Day, 1994; Glaser & Deane, 1999; Lindsay, 2002; Lindsay et al., 2004; National Crime Prevention Council Canada, 1995). A direct comparison of the Northern study to the
literature is not possible due to the lack of a formal mental health diagnosis on 64% of the files. Of those files with diagnoses recorded and with the exception of recognition of sexual offending behaviour, the most frequent DSM-IV diagnoses were for Attention Deficit Hyperactivity Disorder (32.3%), followed by Oppositional Defiant (7.37%), and with Conduct Disorder and Mathematics Disorder tied as the third most frequent diagnoses (5.26%). Although 12.9% of the cases had a history of attempted suicide, they were not formally diagnosed as suffering from a depressive episode at the time of their assessment.

One of the key components to the YFPS assessment is ascertaining the youth’s mental health status. During the past year, accreditation efforts at YFPS have resulted in standards for assessments that include documenting a DSM\textsuperscript{13} diagnosis on each file. Because many of the files reviewed for this study were completed prior to enforcement of this standard, 61 of the 95 northern files (64%) did not have a discharge DSM diagnosis included. The data file provided to me by the Burnaby research team did not indicate that individual DSM diagnoses had been recorded for each case, however, they did code for ADHD (57.8% of all cases) and Conduct Disorder (56.2% of all cases), revealing rates much higher than those in the Northern study. These rates indicated a significant difference between the studies in respect to frequency of ADHD and Conduct Disorder diagnoses; however it could not be determined if this was the result of the Northern cases having fewer incidences, or if the lower rates in the North were due to the lack of diagnoses recorded on the files.

As YFPS continues to meet the new accreditation standards which came into effect during this study, detailed assessment findings and a DSM diagnoses will be recorded on each client file, allowing future research into the mental health of these clients to provide a

\textsuperscript{13} DSM-IV-TR: Diagnostics and Statistics Manual, version four - text revision is the most recent edition.
more concise description of the mental health diagnoses of the clients and the treatment issues those diagnoses present to the treatment clinicians. Information on the occurrence frequency of mental health diagnoses will also provide valuable information for service delivery and clinician training purposes.

**Fetal Alcohol Syndrome (FAS) & Fetal Alcohol Effects (FAE)**

Few studies were found that specifically assessed the frequency of FAS/FAE diagnoses in the adolescent sexual offender population. Fast, Conry and Looke’s (1999) examination of the incidence of fetal alcohol exposure in the youth criminal population found that over 23% of the youths seen in the YFPS inpatient assessment unit during the period of a year had a fetal-alcohol related diagnosis. Of the cases in the Northern study, only 6.50% had ever been formally assessed and diagnosed with a fetal-alcohol related diagnosis. Due to the lack of studies found on this topic, no conclusions can be drawn about the similarities or differences between the literature and the Northern population.

What is certain, however, is that the minimum percentage of youths in the Northern study who had been exposed to alcohol in utero was high, at 36.60%. Due to lack of prenatal information and mothers’ unwillingness to admit to consumption of alcohol during pregnancy, I speculate that the actual number of youths exposed to alcohol during neurological development in utero is much higher. This finding highlights the importance of the pre-treatment assessment and reaffirms the conclusions of those who maintain that the special learning needs of the youth must be determined and considered when planning treatment interventions (Fast, Conry & Looke, 1999; Hunter, 2004).
Of the youths in the Burnaby study, less had been exposed to alcohol in utero, but more had received a formal diagnosis of FAS or FAE (9.80%) than youths in the Northern study. The difference between the studies was significant, with the incidence of fetal alcohol exposure in the Northern study (36.60%) being double to that of the Burnaby study (18.30%). While more youths of First Nations ancestry (20.40%) were exposed to alcohol in utero than were Caucasians (16.10%) in the Northern study, the opposite was true for the Burnaby study, where more Caucasians (7.30%) were exposed than First Nations (6.10%).

A few possible explanations for the differences between the studies in regards to prenatal alcohol exposure may be in the accuracy of information provided about the youth’s pre-natal development, a geographical difference in education and media exposure about the harm of alcohol consumption during pregnancy, or a difference in the rate of alcohol use by people in the two geographical areas. While I speculate that the rates of alcohol abuse in the First Nations populations in Northern British Columbia is a contributing factor, further research into the reason for this difference would be of assistance to those working to reduce the incidence of FAS/FAE in our communities.

Criminal Histories

Fortune and Lambie (2004) found 67.9% of their 131 subjects had a history of delinquent and non-sexual criminal activities prior to committing a sexual offense. Sperber (2003) found almost 50% of her sample had a prior criminal conviction. Similarly, over 40% of the Northern cases had a history of involvement with police prior to the index offense, and 42.6% had committed a prior criminal offense. Over three percent had committed a prior sexual offense. The individual types of prior criminal offences were not
recorded during data collection for this study, a factor to be considered in future studies in order to provide more information into the types of criminal activity the youth engages in prior to sexually offending.

Contact with the police prior to the sexual offense was more prevalent in the Burnaby sample (62.7%) compared to the Northern study (43.6%). The youths in the Burnaby study also had a history of more criminal behaviour: 66.7% had committed non-violent criminal offenses, 42.4% had committed violent offenses, and 17.8% had committed a prior sexual offense. As discussed under the Gender and Ages heading, I speculate that the difference in prior sexual offenses may be attributed to youths in the North being brought before the court and referred to YFPS on their first offense more often than youths in Burnaby. However, that does not explain the difference in criminal histories.

A study on the reasons for, and timing of, referrals to YFPS by the court may offer some explanation into the differences in criminal histories of the youths. I speculate that in the more populated areas of the province, referral to YFPS is used by the court more as a "last resort" to redirect a youth that has not responded to prior consequences, whereas in the North, the courts refer youths to YFPS for assessment and intervention earlier in the youth’s criminal career in order to increase the chances for successful interventions. In addition, Sockett-DiMarco (2001) found that youths who committed only sexual offenses showed less aggression, delinquency and antisocial behaviour than those youths that committed both sexual and non-sexual criminal offences. From a treatment perspective, tracking the recidivism rates of those youths who offended both sexually and non-sexually may assist in the development of more individualistic treatment programs based on criminal activities.
Multiple Victims

In addition to victims of non-sexual criminal behaviour, the literature shows that the majority of sexual offenders have more than one sexual offense victim (Epps & Fisher, 2004; Kahn & Chambers, 1991; Longo & Groth, 1983). In agreement with the literature, 58.95% of the youths in the Northern study had sexually offended against two or more victims. Fewer cases of multiple victims were noted in the Burnaby data, with 20.4% recorded as having more than one victim. The difference between the two studies is attributed to the different coding strategies employed, with the Burnaby researchers recording primarily index offense data only, whereas information on all known victims was recorded in the Northern study.

The consensus in the literature is that the majority of victims of sexual abuse do not disclose their victimization immediately and some do not disclose until years later (Alaggia & Kirshenbaum, 2005; Brown & Kolko, 1998; Browne & Finkelhor, 1986; Christodoulides et al., 2005; Finkelhor, Ormrod, Turner, & Hamby, 2005). Given the fact of under-reporting by victims and the consequences for offenders of disclosing additional victims prior to treatment, it is likely that the data collected does not accurately capture all of the victims affected by the offenses committed by youths in the Northern study.

What is evident, however, is that those persons sexually offended against are not the only victims. The literature shows that the victim, the offender, their respective friends and family members, and the members of their community for multiple generations can be negatively affected by a single sexual offense (Conte, 1984; Dallam et al., 2001; Department of Justice Canada, 2006a; Falls, 2001; Feiring & Taska, 2005; Finkelhor, 1990).
Victim Profile

Victim Gender and Age

With 34.88% male and 65.16% female victims, the findings of this study were consistent with the literature; females form the majority of sexual abuse victims (Becker et al., 1989; Falls, 2001; Hunter et al., 2003) and the younger the age of the victim, the greater the chances that the victim will be male (Davis & Leitenberg, 1987; Gingell, 1993; Groth, 1977). Bernet and Dulcan (1999) reviewed the literature and found that 90% of sexual abuse victims are between three and 16 years of age, with the majority of the victims of adolescent sexual offenders at age nine or less. Of those, 25-40% were under six years of age. The findings in the Northern study also supported Bernet and Dulcan’s information: 84.9% of the victims in this study were between the ages of three and 16 years, and 40.9% were under the age of six.

Over 280 direct victims of adolescent sexual offending were represented in the combined data of the Burnaby and Northern studies. As in the Northern study, females also formed the majority in the victim analysis of the Burnaby data: 33.59% of the Burnaby victims were male, and 63.36% were female. The ages of the victims in the Burnaby study were also similar to those in the Northern study, with 78.6% of all the Burnaby victims being under the age of 12 years, and 38.8% were under six years of age at the time of their sexual victimization.

The information collected on the victims of the youths in the Northern and Burnaby studies agreed with that in the literature, revealing that the victim profile for adolescent sexual offenders has not changed significantly during the past 15 years. As was repeatedly noted in the literature during the past two decades, the victims of adolescent sexual
offenders tend to be females, with both males and females appearing in the victim group of the younger victims. The majority of victims were noted to be under the age of 12. In fact, of the victims in the Northern study, 28.29% were some of our communities’ most vulnerable members: children aged five years or less.

The finding that over a quarter of the victims are five years old or younger is alarming; it indicates that the abuse is taking place at a time when, developmentally, children are developing attachments and trust in others. Being a victim of abuse during this stage of development risks the victim becoming unable to develop and sustain positive relationships with others in their future, and increases the likelihood that they will not develop normally intellectually or socially (Gardner, 1982). As most children access sexual abuse prevention programs when they are in school, the programs to prevent sexual abuse are arriving too late for over 28% of the victims. Therefore, this finding indicates the need for earlier education and intervention programs for parents of preschool children to increase their awareness of the risk of sexual victimization so they can better protect their children.

Victim Relation to Offender

Casual acquaintances and family members constitute the largest victim groups for adolescent sexual offenders. Gingell (1993) reported on the relationship that victims of adolescent sexual offenses had to their offender from data collected by British Columbia Youth Court Services over a seven year period. That data showed the victim’s relation to their offender as follows: 30% were casual acquaintances, 23% were strangers, 17% were babysitting clients, 15% were siblings, 10% were relatives, 4% were schoolmates, and 2%
were foster siblings. Similarly, Fortune and Lambie's (2004) study found 59.5% of the victims fit in the category of casual acquaintance, while 34.2% of the victims were family members and 6.3% were strangers. The data from the Northern study shows the largest percentages of victims (49.03%) were family members, particularly siblings (29.68%). Casual acquaintances formed the second largest victim category at 44.52%. When the data from the Youth Court Services report was recoded to match the categories of the Northern study, the smallest victim group is also that of strangers. However, the Northern study’s percentage of strangers (5.16%) was much less than that of the Youth Court Services’ data at 23%.

Consistent with the literature and the Northern study, the findings of the Burnaby study showed the largest victim group was family members: 45.5% of the victims were family members, 38.6% were friends or acquaintances and 15.8% were strangers. Again, there was a higher rate of offenses against strangers in the study from Burnaby, a more populated areas of the province, than was found in the Northern study.

It is evident from the literature and these two compared studies that adolescent sexual offenders do not offend primarily against strangers. Although the percentage of strangers victimized in the literature and in the Burnaby study is higher than that of the Northern study, the reason for this difference could be attributed to the population differences between the study locations; the literature data and the Burnaby information was collected primarily from large urban areas. For youths in the Northern area of British Columbia residing in smaller communities, it is more likely that they would be able to identify most people in their small community as someone known to them. As a result of
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knowing the victim’s family name or the victim’s relations in the community, the offender would likely consider the victim as a *casual acquaintance*, rather than a *stranger*.

In years past, the stranger was portrayed as the one to avoid; many of today’s adults may recall being a child and hearing, “Never talk to strangers” or being subjected to school videos about the risks of taking rides from strangers. While those messages may still protect some children from abuse, it is evident that the information that a child is more likely to be sexually abused by someone in their own family or circle of friends needs to be reinforced with parents and caregivers if we are to better protect our children.

*Characteristics of the Index Offense*

*Index Offense Location*

Most sexual offenses occur in the victim and/or offender’s home. Gingell (1993) reported that 55% of sexual offenses took place in the home of the victim, and 20% took place in the home of the offender. Danni and Hampe (2000) found that 61.90% of the sexual offenses in their study took place in the offenders’ own homes, and 51.79% took place in the victim’s home; the overlap was due to incidences where the offender and victim resided in the same home. This was also the finding for 67.74% of the offenses in the Northern study: 19.35% took place in the victim’s home, 20.65% in the offender’s home, and 27.74% took place in a home where the victim and offender resided together.

The offenses included in the Burnaby study were coded as either taking place in a home (78.6%), in a place accessed by the public (17.5%), or in a place accessed by the public (3.9%), supporting the findings in the literature that most sexual offenses perpetrated by adolescents are taking place in private homes. Again, the data supports the literature’s reports that the offender is often known to the victim, and the numbers indicate that many
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children are being sexually abused where people would expect a child to be safest: in their own home. What the numbers do not provide, however, is an understanding of the implications for intervention when the offender and victim are siblings.

Under those circumstances, the parent faces the unenviable choice of having to move either the offender or the victim out of the home to prevent further offenses. Many parents try to be supportive of the offender and keep him in the home, however the child protection division of the Ministry of Child and Family Development recognizes the risk to the victim, emotionally and physically, and will often intervene, removing the victim from the home if the parent does not remove the offender. This creates a situation where the victim is essentially revictimized by being taken away from family. In those cases where the offender is moved out of the home, the separation can risk increased feelings of abandonment and rejection for the youth, noted in the literature to be contributing factors to sexual offending behaviour (Hanson & Morton-Bourgon, 2005; Hunter et al, 2003).

Although there are negative consequences for the family when either the victim or the offender leave the family home as a result of incestual offenses, having a suitable placement for the offender and treatment services close to the family may minimize the separation and provide opportunity for the family and victim to participate in treatment for the benefit of all parties. In terms of intervention, in contrast to Burnaby, this means more localized placements and trained clinicians are needed in northern British Columbia.

*Offense Specifics*

As depicted in the literature, a significant number of sexual offenses take place when the offender is given the responsibility to care for younger children (Fehrenbach et
al., 1986; Hunter et al., 2003). The findings of this study showed the Northern sample replicated the findings in the literature, with 25% of the offenses committed while the youth was babysitting. A comparison of the types of sexual offences was made difficult by the inconsistent terms used in the literature to describe sexual offending behaviour. For example, some studies used the term rape to refer to a sexual assault, whereas others reserved that term for sexual assaults which included penile-vaginal penetration. Some researchers referred to the offender as a child molester when the offense was against a child and a rapist when the sexual offense was against an older adolescent or an adult; however they neglected to provide the ages of the offenders. Other studies referred to the sexual offenses as either a hands-on offense (direct contact) or hands-off offense (e.g. exhibitionism) without specifying the criminal code violation which would have allowed comparison to this study.

In the literature, the most common offenses were: indecent assault, also called sexual touching and indecent liberties (47-59%); rape, including sodomy (10-23%); and exhibitionism (6-12%) (Fehrenbach et al., 1986; Fortune & Lambie, 2004). The offenses committed by the youths in the Northern study appeared to deviate from the findings in the literature due to the highest percentage of offenses being for a violation of Section 271 of the Criminal Code of Canada; 59.28% of the offenses in the study were sexual assaults, followed by sexual interference (Sec.151 violation) at 14.43%.

I suspect that the high rate of sexual assaults found in this study is due to the inclusion of sexual touching offenses in the definition of sexual assault in the Criminal Code of Canada. The presence or absence of penetration during the offense was not included in the data collection, so I was unable to differentiate those sexual assaults which
involved touching from those which would have been classified as rape had they been included in an American study.

As with the Northern study, approximately a quarter of all the offences in the Burnaby study took place when the youth was left to care for younger children (27.3%). Almost twice as many of the offenders in the Burnaby study threatened their victims during the commission of the offenses than did youths in the Northern study (36.8% and 19.6%, respectively). In both studies the commission of a sexual offense while under the influence of alcohol was lower than the rates reported in the literature. The type of sexual offense committed by the youths in the Burnaby study was not labeled for identification in the data file, so a direct comparison of types of offences could not be conducted.

According to the findings of this study, there is little difference in the type of offenses being committed by youths in British Columbia and the research subjects depicted in the literature. What is of concern, however, is that data from over 20 years ago showed that over a quarter of the sexual offenses were committed against young children by an adolescent left in the role of caretaker, or babysitter, and that the results of this and the Burnaby study show that rate continues to be the case today. That information, coupled with the information that some of the common characteristics of adolescent sexual offenders are social ineptness and peer isolation (Feherenbach et al., 1986; Hudson, Ward & McCormack, 1999; Maag, 2005) raises the question of whether the high rate of sexual offending while babysitting is due primarily to opportunity, or are the characteristics of the youths that baby-sit predictive of offense risk? In other words, are youths between the ages of 15-17 years available for babysitting because they are not socially involved with their peers due to social ineptness and peer isolation? Further research into the link between
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sexual offending and childcare may be warranted, however Ryan’s (2005) statement, “The most important thing we’ve learned in the past 20 years is that interpersonal violence is predictable and preventable” (p.132) identifies the importance of prevention through awareness of the results of research.

Conclusions

The findings of this study demonstrate that some significant differences exist between the clients in Northern British Columbia and those in the literature. First, the clients referred to the Northern YFPS clinic represented a significantly different ethnic profile, with more youths of First Nations ancestry in the Northern study than were represented in either the Burnaby study or other studies in the literature. In terms of treatment differences, the findings indicate that a different approach is needed in northern British Columbia, one which provides more culturally-specific interventions. Second, although the gender and ages of all the youths at the time of their offenses were very similar, the time lapsed between the commission of the offences, involvement in the youth court system, and referral to YFPS for assessment or treatment were markedly different between the Northern and Burnaby studies, with Northern youths taking almost twice as long to be referred to YFPS for intervention services. This means that youths who sexually offend in northern British Columbia are being left unsupervised and untreated in their communities longer than youths who sexually offend in the Burnaby area. This finding identifies an urgent need for further investigation into the reason for the long delays in the north so they can be eliminated.
In addition to having to wait longer to be referred to YFPS, northern youths also faced significantly longer distances to travel in order to access YFPS assessment and primary treatment services. Sixteen percent of the clients were required to travel over 500 kilometres to reach the Prince George YFPS clinic from their home community. Of those, 87% were of First Nations ancestry. Although this is evidence of how northern British Columbia’s ethnographic topography affects service delivery, it highlights the need for trained clinicians capable of providing primary treatment to be more easily available to rural youths, particularly those of First Nations ancestry.

The assessments conducted at the northern YFPS clinic confirmed the findings of Ferrara and McDonald (1996) that youths that commit sexual offences often show a performance intelligence quotient (PIQ) which is greater than their verbal or full scale intelligence quotient. The assessments also revealed there were no significant differences in IQ scores between the two studies on YFPS client populations. However, the findings provided evidence that the IQ testing on youths of First Nations ancestry results in IQ scores averaging 9.58 points lower than the results on Caucasian youths, calling into question biases in our testing tools and educational system and identifying the need for assessment tools normed to our northern population.

At school, the youths in the Northern study were found to be similar to youths in both the Burnaby study and published articles on adolescent sexual offenders (Browne & Finkelhor, 1986; Foley, 2001; Kahn & Chambers, 1991; Knight & Prentky, 1993; O'Brien & Bera, 1986; Ryan et al, 1996; Shields, 2004): the majority have a history of learning difficulties and demonstrated problem behaviours in the classroom setting. Outside the classroom, a majority of the youths in the Northern study used alcohol and illegal
substances, indicating the importance of interventions addressing drug and alcohol issues. Less than 10% of the youths in the study were under the influence of alcohol or a drug when they committed their offences, but of those who were under the influence when they committed a sexual offence, the majority were of First Nations ancestry, supporting prior research findings on the links between alcohol abuse and offending rates in First Nations people (Moore, 2003), and clarifying the importance of abstaining from alcohol as part of their relapse prevention plan. Further, the number of youths exposed to alcohol in utero in the Northern study (36.60%) was double that of the youths in the Burnaby study: an important treatment consideration for this population in northern British Columbia. Youths affected with fetal alcohol exposure require special interventions designed to compensate for their limitations, a factor currently taken into account in the provision of sexual offense treatment in northern British Columbia, but one needing to be recognized in the development of program standards by those headquartered in more populated areas of the province.

In respect to criminal activity and victim selection, the findings of this study were consistent with those in the literature; over 42% had committed a prior criminal offense, although only 3% had a prior sexual offense. The majority had more than one victim, and they selected female victims less than six years in age with whom they were already familiar, often a relative or an acquaintance. They tended to commit their sexual offenses in their own home, the home of the victim, or a home they shared, with a quarter of the offenses taking place when the youth was babysitting the victim. Thus, interventions in both the Vancouver Coastal and Northern regions must include increased awareness in all
family members, and the development of supervision rules to restrict access to potential
victims in these locations.

In summary, the youths referred to YFPS in Northern British Columbia after the
commission of sexual offenses possess the same characteristics as found in similar
populations in the literature, however the YFPS clients in Northern British Columbia
present their clinicians with a challenging and distinctive combination of ethnic and
cognitive profile, treatment issues, and service delivery obstacles not depicted in previous
literature.

Recommendations

The findings of this study raise several key issues, both in the assessment and
treatment of youths who commit sexual offences, and in our efforts to prevent the sexual
victimization of children. The recommendations that follow address access to assessment
and treatment for these youths, the ethnic influence on assessment and treatment services,
the high rate of exposure to alcohol in utero in this population, and, finally, means to
reduce the sexual victimization of children through parental education.

One of the primary factors in youths accessing assessment and treatment services
through YFPS is the requirement for youths to be referred to the service. The finding that
the delay between the commission of the offense and the referral to YFPS in Northern
British Columbia was significantly longer than the delay in the metropolitan area of the
province requires further investigation. A closer examination of the judicial process may
reveal between which dates, specifically, that the delay is created. It may be that it takes
longer in Northern British Columbia for: (i) victims to report the offenses; (ii) the RCMP to
Youth who sexually offend respond to reports or to complete investigations; (iii) the Crown Counsel to approve charges and have the matter before the Court; (iv) the Court to order pre-sentence assessments; or (v) the Probation Officers to refer the youth to YFPS for treatment. Further research may determine how the delay can be reduced in order that youths who commit sexual offences access intervention services promptly.

In respect to access to services, the expanse of Northern British Columbia contains many small communities to which Youth Forensic Psychiatric Services (YFPS) is mandated to provide assessment and treatment services. Although a full service YFPS clinic in each community would allow for more comprehensive assessment and treatment options, the fact remains that a full service YFPS clinic in each community is not a financially viable option. Especially for assessment purposes, it is more cost-effective and service-efficient for youths to travel to the YFPS clinic in Prince George than for the doctors and clinicians to travel to the small communities. Recognizing that having clinicians trained to provide the primary treatment in the home communities would allow for better utilization of local support services and family inclusion in the treatment model while reducing travel obstacles, the northern YFPS clinic has recently established trial satellite treatment clinics, staffed by a trained clinician or contractor, allowing some youths to access primary sexual offense treatment in their own community. Further research into the cost and treatment efficacy of these satellite clinics may prove the model to be an effective and viable option to having the youths housed in Prince George, separated from their families for a year or more to access treatment.

The problem of improving access to assessment services, however, is not as easily solved. Although British Columbian universities produce psychologists and child
psychiatrists annually, the number of those with education and experience in the field of forensics assessment and treatment is few, and of those, fewer are willing to reside in northern British Columbia, and fewer still are willing to accept a full time position with YFPS for the salary being offered by the government, a salary which is not comparable to the income potential of qualified personnel in private practice. Therefore, qualified personnel who reside in the metropolitan areas of the province and who are willing to travel to Prince George for a few days each month to conduct assessments, are contracted at substantial travel and accommodation expense. As a result, families in northern British Columbia are not only required to travel great distances to access the Prince George clinic, but they are required to do so on those days the doctors are in Prince George, regardless of whether or not those dates are convenient to the family, and often in winter conditions.

Clearly, making full time positions more lucrative may entice doctors to leave the metropolitan areas and relocate to northern British Columbia. However, focusing on personnel that have already chosen to live in northern British Columbia may be a more successful method. One solution to the problem may be an incentive for current YFPS employees to obtain the training and education required to meet the requirements to conduct assessments, namely, a doctorate degree. Although YFPS offers its employees excellent training opportunities as well as financial assistance to cover tuition costs to further their education, under the current union contracts covering employees of the government of British Columbia, there is no significant advantage to be gained for employees who do further their education; their salary is dictated by years of service and is tied to a grid-system for their specific job title. Therefore, there is little incentive for employees to take on the difficult task of advancing their degrees while maintaining their
employment position in order to add assessment services to their list of responsibilities at the workplace.

Another avenue to increase interest in the field would be for graduate students at the University of Northern British Columbia to be given the opportunity to take courses related to forensic psychiatric services for credit towards their graduate degrees. Given the high costs of living and tuition, few students can afford the luxury or time required to attend additional courses just for interest. By offering graduate level courses in forensic assessment and treatment, more students may graduate with an interest in a career with YFPS in northern British Columbia.

One of the key differences between the findings in the literature and those of this study is the ethnic composition of the populations. The large proportion of First Nation youths in northern British Columbia plays an influential role in the provision of assessment and treatment services. Research is required to address the difference found in the mean IQ scores between the First Nation and Caucasian clients. Although the psychometric tests used have been normed on adolescents of the appropriate ages, they were not normed specifically on populations mirroring the ethnic composition found in northern British Columbia. I suspect that psychometric tools designed to test IQ, but created and normed purposely for our First Nation population in northern British Columbia will result in changes to the mean IQ scores found in future studies.

Until then, education and training focusing specifically on First Nation customs, culture, learning preferences and traditional interventions would be of assistance for clinicians working with those youths who identify themselves as belonging to the First Nation population. In addition, I expect that youths of First Nation ancestry who struggle
with their ethnic identity would benefit greatly from working with clinicians who are aware of the difficulties encountered by youth attempting to find a balance between their First Nation heritage and the media's representation of urban Caucasian culture.

Another difficulty is the over-representation of First Nations peoples involved with the justice system as a result of alcohol abuse. Although those statistics speak to the number of First Nations people who committed criminal offences while under the influence of alcohol, this study also shows a high number of youths had been exposed to alcohol in utero and are now involved with the justice system. For those youths currently in our communities who were born after being exposed to alcohol in-utero, treatment and intervention services must take into account the learning challenges they face through no fault of their own. The promotion and support of community and medical programs that assist in the early identification of children born after fetal alcohol exposure could ensure those youths receive early assessment and intervention services. Ideally, identification of youths affected by fetal alcohol exposure would occur prior to these children encountering negative experiences in school and social settings so that measures to control socially inappropriate behaviours may be put in place. These include continuous supervision, advocacy, and training for them in problem solving and decision making skills.

The findings of this study indicated that adolescent sexual offenders in Northern British Columbia differed from those in the literature; however, due to the limited scope of this study, I could not determine if adolescent offenders in Northern British Columbia differed from adolescents who committed other types of criminal offences. Further research may reveal that these differences are not unique to those who sexually offend, but are common to all types of adolescent offenders in the northern region of British Columbia.
The findings of this study also indicate that more attention needs to be given to reducing the number of victims by educating the parents of potential victims. As noted in the Discussion section in the previous chapter, the victims of adolescent sexual offenders tend to be females, usually under 12 years of age. The majority of victims are children less than six years old, and both males and females appear in this youngest victim group.

The victim profile has not changed significantly during the past few decades, yet children continue to be sexual abused. With such a high percentage of victims under school age, the findings of this study highlight the need for parents to be participating in sexual abuse education and prevention programs long before the child reaches six years old. Increased education for parents on the frequency of child sexual abuse, the common characteristics of youths that commit sexual offences, the rate of offences that take place during babysitting sessions, and the signs and symptoms of sexual abuse may reduce the number of offences taking place and provide for earlier identification and intervention of victims of sexual abuse. In addition, the importance of teaching toddlers and pre-school children about sexual abuse prevention, such as knowing the difference between appropriate and inappropriate physical contact, cannot be understated for it may reduce the number of young children that fall victim to sexual offending behaviour.

Ultimately, prevention will be the key to reducing the number of victims. In a field still shrouded by shame and secrecy, researchers studying offender characteristics, treatment efficacy, and victim prevention may need to integrate marketing research to raise awareness of adolescent sexual offending behaviour so preventative interventions can replace the need for assessment and treatment of offenders and victims.
In conclusion, this study has determined that youths in northern British Columbia who sexually offend have different demographical characteristics than those in Burnaby and in the literature, and have more difficulty accessing assessment and primary sexual offense treatment. This study has also provided evidence that a specialized sexual offense treatment program, which takes into account the regional and ethnical differences, would be justifiable for the northern region.

Ideally, this study will motivate social workers, and other professionals, to provide education to parents of preschoolers to increase public awareness of sexual offending behaviour and reduce the risk of sexual abuse for our preschool children, and will encourage researchers to examine some of the discrepancies found between the Burnaby and Northern studies. Specifically: the reason for the ethnic differences found on the psychometric test results; the reason for the higher frequency of diagnosed learning disabilities for First Nations youths; and the cause for the extended lapse time between offense and referral to YFPS for youths who commit sexual offences in Northern BC.
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Appendix 1

Literature Review Search Strategy

Databases

In addition to hand-searched journals and texts, the following electronic databases were searched for references:

1. Academic Search Premier
2. ArticleFirst
3. IngentaConnect
4. netLibrary
5. PapersFirst
6. ProceedingsFirst
7. ProQuest Digital Dissertations
8. ProjectMuse
9. Theses Canada
10. Canadian Research Index
11. CBCA Education
12. Statistics Canada Catalogue
13. Women’s Studies International
14. Education: SAGE Full Text Collection
15. ERIC
16. Primary Search
17. PsycARTICLES
18. PsycINFO
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19. Sociology: SAGE Full Text Collection
20. Bibliography of Native North Americans
21. First Nations Periodical Index
22. Humanities Full Text
23. Social Sciences Full Text
24. DSP E-Collection
25. Alt-HealthWatch
26. BioMed Central
27. CINAHL
28. General Science Index
29. Health Science: A SAGE Full-text Collection
30. MEDLINE
31. Native health databases
32. Psychology: SAGE Full Text Collection
33. Criminology: SAGE Full Text Collection
34. Sociological Abstracts
35. Child Abuse, Child Welfare & Adoption Database
36. National Criminal Justice Abstracts
37. Psychology and Behavioral Sciences collection
38. Nursing & Allied Health Collection
39. Cochrane Database of Systematic Reviews
40. Databased of Abstracts of Reviews of Effectiveness
41. Cochrane Controlled Trials Register
42. StatMaster Index

43. Academic Search Elite

*Web-Based Sources Accessed*

In addition, I accessed the following online resources:

1. Google Scholar
   
   <http://scholar.google.com/>

2. Entrez PubMed
   

3. FirstGov.gov
   
   <http://www.firstgov.gov/>

4. Forensic Science Resources
   
   <http://www.tncrimlaw.com/forensic/f_psych.html>

5. American Psychological Association
   
   <http://www.apa.org/about/publicprod.html>

6. Centre for Addiction and Mental Health
   
   <http://www.camh.net/Research/index.html>

7. Statistics Canada
   
   <http://www40.statcan.ca/l01/cst01/>

8. National Clearinghouse on Family Violence
   
   <http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/nftsabus_e.html>

9. Correctional Service of Canada
   
   <http://www.csc-scc.gc.ca/text/publictitle_e.shtml>

10. Center for Sex Offender Management

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11. Directory of Open Access Journals
   <http://www.doaj.org/>

12. Department of Justice Canada

13. Office of Juvenile Justice and Delinquency Prevention
   <http://www.ojjdp.ncjrs.org/juvsexoff/sexbibtopic.html>

14. Health and Human Services Library
   <http://admin.moh.hnet.bc.ca/libinfo/journals/toc/>

15. Police Services – Ministry of Public Safety and Solicitor General
   <http://www.pssg.gov.bc.ca/police_services/publications/index.htm>

16. Psychology Books Online
   <http://www.psychnet-uk.com/books/books_online.htm>

17. World E-Book Library
   <http://netlibrary.net/References.htm>

18. Applied Psychology in Criminal Justice
   <http://www.apcj.org/>

19. Irish Journal of Psychological Medicine
   <http://www.ijpm.org/index.html>

20. The Prevention Researcher
   <http://www.tpronline.org/articlesection.cfm>

21. PsychCrawler
   <http://www.psychcrawler.com/>
 Specific searches for the names of known authors, titles, and programs were conducted with variations on the following search strategies, used either singly or in combination:

- (sex* offen*), (sex* devia*), (child* molest*), (child* sex* abus*), (sex* assaul* or sex* viol* or viol* offen*), (effect* or damag* or consequen* or result* or cost* or impact* or outcom*), (pedophil* or paedophil*), (rape or rapist), (incest*), (sex* behav*), (inapprop* touch*), (sex* bound*), (background* or histor* or detail* or famil*), (character* or trait*), (categor* or typ* or taxon*), (crim* behav* or viol*), (forens* or psych* or just* or crim* or court*), (custod* or prison* or police* or probation* or supervis*), (youth* or adoles* or juven* or child*), (interven* or treat* or prog* or educ*), (assess* or interview* or report*), (eval* or effic* or recid* or reoffen* or outcom*), (predic* or diagnos* or identif*), (mental* or intellect* or cognit* or brain* or learn* or achiev*), (function* or difficul* or impair* or retard* or develop* or challeng* or handicap* or disab* or disord* or defic* or spec* need* or low*), (fetal alcohol* or FAS* or FAE* or matem* drink* or gestation* expos* or ADD or ADHD ), (clinic* or therap* or counsel* or servic* provid* or resourc*), (rural* or remot* or communit*).
Appendix 2

Definitions

Adolescent. For the purposes of this study, I use the terms adolescent and youth interchangeably to refer to persons between 12 and 18 years of age.

Alcohol use/abuse/addiction.

Social use  a) drinks or uses rarely, such as wine at special occasions under parental supervision, and
b) hasn't experienced intoxication or problems of any kind associated with drinking or using, and
c) others have not complained or expressed concern about the youth's substance use

Abuse  a) uses alcohol or drugs to help change the way they feel about themselves and/or some aspect(s) of their lives
b) experienced some problems associated with their alcohol or drug use but used those experiences to set appropriate limits on how much and how often they drink or use
c) rec'd complaints about their drinking or using and youth accepted those complaints as expressions of concern for their well-being.

Addiction  a) experienced negative consequences associated with drinking or using but continued to drink or use despite those consequences
b) sets limits or make promises on how much or how often they will
drink or use but exceed those limits or break those promises
c) have experienced negative feelings about their drinking or using
but still fail to permanently alter the way they drink or use
d) get complaints about their drinking or using and resent, discount,
and/or disregard those comments and complaints.

_Cognitive disability._ (Also referred to in the literature as _Learning Disabled, Cognitively
Challenged, Mentally Handicapped, Mentally Retarded or Special Needs_). For the
purpose of this study, the term _Cognitive Disability_ was used to refer to youths who
demonstrated difficulty with some mental tasks for one or more of a variety of
reasons, including:

a) an IQ of 70 or less based on standardized testing,
b) Attention Deficit (and/or Hyperactivity)Disorder,
c) Fetal Alcohol Spectrum Disorder,
d) neuro-developmental delays, as determined by neuropsychological testing,
e) brain injury,
f) learning disorder, with or without intelligence deficit or
g) a history of deficiency in social skills as identified by clinicians or community
professionals.

_Contractor._ A person contracted through a Youth Forensic Psychiatric Services clinic to
provide assessment and/or treatment services to youths in communities not readily
accessible to the main clinic.

_Index offence._ The sexual offence for which the client was charged.
Northern British Columbia. The region of British Columbia whose borders are from Haida Gwaii (formerly known as the Queen Charlotte Islands) on the West coast across to the Alberta border on the East, and from 100 Mile House in the South to the Yukon Border in the North. This region, consisting of over half of the landmass of the province, approximately 400,000 km², with a population close to 440,000, is the area for which the Prince George YFPS clinic is responsible to provide service.

Paraphilia (specified). The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) criteria for Pedophilia (302.2) are:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child or children (generally age 13 years or younger);

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty; and

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

The specific paraphilias are as follows: (i) exhibitionism, (ii) fetishism, (iii) frotteurism, (iv) pedophilia, (v) sexual masochism, (vi) sexual sadism, (vii) transvestic fetishism, and (viii) voyeurism.

Paraphilia (NOS). In addition to the eight specified paraphilias listed in the DSM-IV, there are paraphilias identified as not otherwise specified (NOS):

"The diagnosis of paraphilia not otherwise specified (NOS) is used for sexual fantasies, urges, and behaviors that meet the general criteria for paraphilias but

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involve objects of arousal other than those cited earlier. Examples of this include telephone scatologia (obscene telephone calls), necrophilia (sexual activity with corpses), partialism (sexual activity focused on one part of the body such as feet), klismaphilia (erotic attraction to and stimulation by enemas), zoophilia (sexual activity with animals), urophilia (involving urine), and coprophilia (involving feces). Sexual arousal focused on telephone or Internet conversations as a culminating sexual activity rather than as a prelude to or temporary substitute for conventional sexual activity between consenting adults may be viewed as new additions to the list of paraphilias” (Seligman & Hardenburg, 2000, p.111)

**Probation officer.** An employee of the Government of British Columbia, responsible for supervising youths in conflict with the law and supporting the youth’s adherence to court ordered conditions as prescribed under the Youth Criminal Justice Act (2002).

**Probation order.** An order by the court requiring the offender to abide by any number of conditions determined by the judge to be necessary for the safety of the community, and the rehabilitation of the offender.

**Sexual offense.** Any of the following sections of the Criminal Code of Canada that relate to sexual offending:

- Section 151 - Sexual interference
- Section 152 - Invitation to sexual touching
- Section 153 - Sexual exploitation
- Section 153.1 - Sexual exploitation of a person with a disability
- Section 155 - Incest
- Section 159 - Anal intercourse
Section 160 – Bestiality

Section 163.1 – Child pornography

Section 172.1 – Luring a child (via computer)

Section 173 – Indecent acts

Section 271 – Sexual assault

Section 272 – Sexual assault with a weapon, threats to a third party or causing bodily harm

Section 273 – Aggravated sexual assault

In addition, when committed with a sexual purpose:

Section 177 – Trespassing at night,

Section 430(1) (c or d) – Mischief, or

Section 810 – Fear of certain offenses (Department of Justice Canada, 2002).

Sexually intrusive. Behaviour exhibited by a youth for which the youth has not been held criminally responsible. This includes, but is not limited to, non-consented fondling, frottage, digital/penile/object penetration of the vagina or anus, oral copulation, voyeurism, exhibitionism, fetishes and obscene phone calls (Charles & McDonald, 1997).

Youth – person aged 12 to 18 years, inclusive

Youth Criminal Justice Act (YCJA) (2002). Current legislation in Canada pertaining to Youth - replaced the former Young Offenders Act.
Appendix 3

Consent letter from Youth Forensic Psychiatric Services

January 12th, 2005

Terry Anne Smiley
1194 7th Avenue
Prince George
B.C. V2L 3P4

Dear Terry Anne,

This letter will confirm that the Program Evaluation and Research Committee for Youth Forensic Psychiatric Services has approved your M.Ed. Research Proposal entitled "Comparing treatment populations in British Columbia: Youth who sexually offend."

You are authorized to collect data from YFPS client files in order to complete your research project as outlined in your proposal.

Sincerely,

[Signature]

Judith Hayes M.Sc.
Regional Manager
### Appendix 4

**Data Collection Tool**

**REFERRAL DATE:**

**DISCHARGE DATE:**

**CLIENT CODE:**

---

**Code Assignment X = not applicable**

**Code 99 = Unknown/Info not available**

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<th>Code</th>
<th>Scoring</th>
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<td>Sex</td>
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<td>Age</td>
<td>at index offence ___yrs__mon (1st occurrence of I.O)</td>
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<td></td>
<td>at admission ___yrs__mon</td>
<td>AgeA</td>
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<td>at discharge ___yrs__mon</td>
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<td>5. 301 – 400 km 6. 401 – 500 km 7. &gt; 500 km</td>
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<td>5. 301 – 400 km 6. 401 – 500 km 7. &gt; 500 km</td>
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<td>Highest completed grade prior to Ax</td>
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<td>Alternate School</td>
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# Youth who sexually offend 261

## CLIENT CODE: __________

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<td>2. stepsibling/ foster</td>
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<tr>
<td></td>
<td>3. cousin</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>4. niece/nephew</td>
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<td>5. friend/acq.</td>
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<td>6. Other public</td>
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| I.O. Charges CCC Charges                       | CCC                                                                                 |      |         |

| Pre-treatment RCMP involvement                | 0 - No                                                                              | RCMP |       |
| Previous offences                             | 0 - No                                                                              | Prior |      |
| Prior convictions for sexual offending        | 0 - No                                                                              | PriorSO |    |
| Index offence while babysitting               | 0 - No                                                                              | Babysit |     |
| Threats used in index offence                 | 0 - No                                                                              | Threats |     |
| Alcohol abuse at time of index offence        | 0 - No                                                                              | Alcohol |    |

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Appendix 5

Permission to Quote

----- Original Message -----  
From: Research and Statistics Publications  
To: TA Smiley  
Sent: Monday, May 01, 2006 8:23 AM  
Subject: RE: Request for permission to quote

Thank you for visiting the Web site of the Research and Statistics Division of the Department of Justice Canada.

We note your request for permission to quote from one of our research reports. As the report belongs to the public domain, you may quote from it as you see fit, provided, of course, that our report is referenced appropriately in your thesis.

Sincerely,

Publication and Dissemination Services | Service de publication et de diffusion
Research and Statistics Division | Division de la recherche et de la statistique
Department of Justice Canada | Ministère de la Justice Canada
284 Wellington Street | 284, rue Wellington
Ottawa (Ontario) K1A 0H8
Fax | téléc.: (613) 941-1845
rsd.drs@justice.gc.ca
Government of Canada | Gouvernement du Canada

---

From: TA Smiley  
Sent: 2006 Apr 30 8:57 PM  
To: Research and Statistics Publications  
Subject: Request for permission to quote

Hello,

I am just completing a master’s thesis, through the University of Northern British Columbia, on the topic of adolescent sexual offenders. In my research, I accessed the following resource:


I would like permission to quote directly the 15 excellent recommendations made by Latimer et al., as listed in the executive summary on pages (i) and (ii). I could not find information on the website describing permissions to quote or procedures for application of same. Please advise?

Thank you,

Terry Anne Smiley