Challenges to Evidence-Informed Practice and Policy Concerning Adolescent Sex Offenders

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Any commentary prioritizing current issues is to some extent subjective. There might be different lists depending on the source. Ask a trial lawyer, and the issues may pertain to court proceedings. Ask a therapist, and the issues may pertain to therapy techniques. My own perspective is that of someone concerned with how science can inform practice and public policy.

The science-practice relationship has prompted quite a bit of dialogue in recent years. For example, the rise of the evidence-based practice perspective has been perhaps the decade's defining issue in social and mental health services. Similarly, the potential role that science can play in public policy has been discussed as a timely priority in a recent *APSAC Advisor* issue (Higgins, Chan, & Ponder, 2006). The ascending influence of research evidence in these areas remains contentious, which should be expected considering that practice and social policy have historically been value and ideology driven. Facts historically have been selectively cited to buttress a pre-existing, value-based agenda rather than used broadly to determine what our agenda should be. Some degree of push-back against the increasing role of scientific evidence is probably natural. It is also not unreasonable—few would advocate that science alone should dictate practice or policy decisions.

Where teens who commit sex crimes are concerned, we have seen fairly limited infusion of scientific evidence into either clinical practice or public policy. Indeed, I would argue that this is a practice and policy area that has not readily embraced scientific evidence. This is a dynamic underlying many current controversies. For example, there have been endless debates over use of polygraph interrogations with these youth, a technique many scientists consider pseudoscience but many practitioners and policy makers embrace with steadfast devotion. In this commentary, I will examine obstacles to integrating science into teen sex offender practice and policy.

Scientific Evidence and Clinical Practice

It is becoming increasingly clear that the fundamental assumptions underlying many current clinical practices with these youth are flatly unsupported for the majority of cases. This applies primarily to the downward developmental translation of adult pedophile-based treatment and management assumptions. These assumptions have translated into a set of clinical practices often, if somewhat imprecisely, labeled as "sex-offender specific therapy." Examples include the use of "cycle" or relapse-prevention techniques (based on the erroneous assumption that youthful sex crimes involve an engrained, stereotypic, compulsive or addictive pattern); reliance on cognitive psychotherapy (based on the doubtful assumption that the problem is more attitudinal than contextual); use of aggressive group therapy techniques (based on the erroneous assumption that peer confrontation is needed to break down denial about hidden deviancy); routine placement in residential facilities (based on the presumed but questionable benefits of massive treatment dose, separation from family and mainstream society, and aggregation with other delinquents); and use of the polygraph (based on the dubious assumption that how much someone sweats during interrogation reveals what they are truly thinking, and the untested assumption that this procedure improves ultimate outcomes). The misperceptions underlying current juvenile sex offender practices—misperceived level of risk, misperceived "specialness," misperceived homogeneity, and misperceived intransigence to change—have been summarized and analyzed in a lengthier paper (Chaffin, in press) for readers who are interested in a fuller analysis of these issues.

Conceptually, the deficiencies of the adult pedophile model applied to youth are not particularly controversial or new (Letourneau & Minor, 2005). In fact, many or perhaps most clinical treatment providers, including many who practice derivatives of adult-model techniques, would probably agree that the adult model adapted downward to teens is a mismatch in most cases. Many would agree that when it comes to practice, something different is needed. The real questions are what that something different might be and how to make the switch. What the something different might be is the easier of the two questions to tackle. It is increasingly clear that multisystemic therapy (MST) not only has better supporting evidence than traditional sex-offender specific treatment but also, according to early findings from a head-to-head randomized trial, that overall outcomes are superior. This might be especially the case where youth have general (i.e., nonsexual) behavior problems and delinquency risks, which is a sizeable concern among teenagers who commit sex crimes. Juvenile-on-juvenile sex crimes are probably similar in many ways to other, nonsexual, juvenile delinquent behaviors, so it is not surprising that what works for the latter will work for the former. Given that MST comprises well-established component elements that are shared in common by many evidence-based delinquency programs (e.g., using focused behavioral techniques, working with and through caregivers rather than in peer group therapy, working to keep teens engaged in school and positive peer activities, increasing caregiver supervision and behavior management skills, and strengthening caregiver-teen relationships and communication), it is quite possible that other evidence-based delinquency programs containing these common elements could also be found to deliver similar advantages compared with traditional sexual deviancy-oriented sex offender group therapy.

The more difficult question is how to get these alternative models and elements adopted and implemented. It is important to consider that the adolescent sex offender treatment system is fairly entrepreneurial in its structure and that it is currently concentrated within small practice and residential treatment facilities. Many community programs for teens who commit sex crimes are housed in individual or small practice offices, which are suited to delivering clinic-based individual or group psychotherapy but may be poorly suited to using MST or related evidence-based models where caseloads are smaller, treatment contacts are less regularly spaced, service durations are shorter, and most service delivery occurs outside of office settings. Moreover, because the adolescent population is diverse, it is likely that emerging best practices will come to dictate very different intervention programs for different

population subgroups. As a result, some of these solutions may be beyond the capacity of small or individual office practices. We may need to consider that some delinquent teens in trouble for sexual behavior could be better served outside of the sex-offender treatment provider world if models such as MST prove too difficult to implement within that world.

Reimbursement issues also pose challenges. Practice in traditional clinical settings is strongly driven by third-party reimbursement contingencies that are notoriously conservative. Such contingencies commonly drive practice in the direction of older (or even obsolete) practice modalities such as office-based individual or group psychotherapy, even when the scientific evidence points toward better and more cost-effective alternatives. Economically, individual or small group practices may depend on long-term clinic-based psychotherapy for their survival and may be inadequately reimbursed for the costs of transitioning to different models. A combination of prohibitive start-up costs and uptake complexities, inertia, competing day-to-day demands, reimbursement contingencies, and emotional ties to old ways of thinking and working may combine to make change unlikely in these settings. Many practitioners would no doubt like to change because they value innovation and because they believe in evidence-based practice, but they find it simply too difficult to make the switch. We need to make it less difficult.

The obstacles to change in residential programs may be even greater. Residential facilities and the corporations that operate them have invested considerable resources and realize substantial income from the practice of placing teens who commit sex crimes in long-term residential treatment to a far greater extent and for far longer times than other youth. The length of stay for these teens is often more than double that of youth placed for other types of serious offenses, and vastly longer than for youth with other serious mental or behavior problems. There is little or no scientific evidence supporting this disparity. This is not to suggest that residential care isn't occasionally necessary but, rather, that current utilization is exaggerated. In this case, making the switch to evidence-informed programming (which would emphasize shorter stays and more community-based care for a substantial portion of the youth currently being placed in long-term care) would not be merely inconvenient or difficult. It would also involve downsizing a large and highly capitalized corporate enterprise that is dependent on established ways of practicing for its cash flow, so we can expect opposition.

Similar challenges to innovation could be observed in any psychosocial practice field. These types of challenges are normally balanced by countervailing market forces, including consumer demand or policy demands. But countervailing market forces may have relatively less influence when it comes to adolescent sex offender practice. Consumer (i.e., patient) demand plays virtually no role in this practice area, and it never really has. In fact, many would take issue with characterizing these teens and their families as the "consumers" at all. Would youth and their families prefer services that were shorter-term, involved lower burden, and delivered greater expected benefit? This is a rhetorical question. These are not voluntary but instead coerced consumers, who often have no choice when it comes to service selection. For example, youth and families may be compelled to receive a particular undesired service from a particular undesired provider, even when an alternative is available that the scientific data might support as having equal or better effectiveness. The stigma associated with being a "sex offender" may make families reluctant to advocate publicly or to organize. Consequently, we cannot expect consumer forces to push much practice change.

Scientific Evidence and Policy

Regulations and policy are another force for change, but these may be constrained for a number of reasons. Few things prompt fear and outrage as do sex offenses. The public and policy makers often are uninformed about the vast differences between youth in trouble for sexual behavior and the sorts of horrific adult sexual predator cases publicized in the media. The actual danger posed by these youth is widely overestimated, but it is not high either in absolute terms or relative to other groups of delinquent youth (Caldwell, 2007). Juvenile probation officers, child welfare workers, and treatment providers, along with their respective supervisors and agency heads, may experience acute concern that one of these cases will "go wrong," and result in a frenzy of blaming and finger pointing. Of course, we should never excuse carelessness, negligence, or incompetence in teen sex offender cases or any others. But the fact is that things can go wrong even when case handling is done in the most responsible and competent ways possible. Public agencies and treatment providers are acutely aware of this reality. Part of this reality is that some of the ways in which cases can go wrong are vastly more visible and therefore more politically risky than others. For example, if a youth is retained in the community rather than institutionalized and things go wrong, the error may be highly visible and viewed as negligent. However, if a youth is institutionalized and becomes more delinquent or dangerous due to his institutional experience compared with what he would have been if he had remained in the community, this failure may not be visible, even if it ultimately causes the same or greater downstream harm to community safety. In this case, it might falsely appear that the system acted better safe than sorry, rather than the reality that the system actually made matters worse.

The illusion created by this visibility imbalance can contribute to a mentality favoring restrictiveness (i.e., more GPS monitors, more expulsion from school, more public notification, more polygraphs, longer lock-up, more remand to the adult system) even if the policy direction taken ultimately makes us less safe in addition to being less humane. Iatrogenic risks (i.e., risks caused by the intervention) may be invisible in day-to-day practice but are easily revealed by rigorous scientific studies, which is one reason science is needed in policy decisions. For example, remanding serious delinquents to the adult criminal system is a policy intended to protect the public. A recent meta-analysis by the CDC revealed that policies for remanding juveniles to the adult criminal justice system probably do more harm than good when it comes to protecting communities from crime (Hahn et al., 2007). It appears that these policies actually increase future crime. Unless we have good scientific data, the public and policy makers may remain unaware of these less visible risks.

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Given the current media and political environment, there are real risks associated with change and innovation. Policy makers may opt for practices that limit political exposure by sticking with conventional methods. Innovation may be seen as risky politically, even if it actually improves community safety. When a case goes wrong, security may lie in the conventional and restrictive, even where it is proven to be iatrogenic, and political risk may lie in trying something different even if it is better. Similar pressures may discourage rigorous and transparent program outcome evaluation, especially controlled experimental study of competing practice and policy options. It may be safer to remain ignorant than to know. Perhaps this is one source of the paucity of true controlled research in this area relative to others. Over a generation ago, Donald Campbell (1969) wrote about the obstacles to innovation, transparent scientific policy evaluation, and evidence-informed social policy in a landmark paper, entitled "Reforms as Experiments." The issues he cited then remain equally current today.

Summary

In this commentary, I have argued that evidence-informed practice and policy with teens who commit sex offenses face particular challenges. Because of this, it may be especially critical for those working in child protection to increase our advocacy for best-evidence supported practices and policies. First and foremost, we must educate the public, policy makers, and the media about the facts, not the urban myths and moral panic, surrounding these youth and their service and management needs. In general, the facts paint a far more positive picture of these youth than most of the public, the media, or our policy makers might imagine, and it will be important for us to get that message out. Even among our peers in the child welfare and juvenile justice fields, there is widespread misinformation. I believe the available facts point us in directions that are quite different from those currently embraced in some state and federal juvenile sex offender management policies and practice standards (Chaffin, in press).

When educating the public, it will be critical that we emphasize both the readily visible and less readily visible risks and benefits of particular practices and policies, and insist that these be rigorously and transparently tested. Many current policies have the potential to do more harm than good in terms of community protection, but the harms may not become visible unless they are studied scientifically. For example, federal policy under the new Adam Walsh Act dictates that 14-year-olds in the juvenile justice system for a sex crime must come under lifetime public sex offender registration. This policy will carry cascading implications for other policies, such as automatic expulsion from school, residency restrictions and family disruption, educational disruption, employability limits, and so on. This could possibly be the single most ill-considered public policy in the history of child protection. In essence, this piece of public policy has limited potential to do good (i.e., these groups of youth pose no extraordinary risk to commit future sex crimes and account for a very small percentage of all future sex crimes) with disturbing potential to make things worse, because marginalizing and excluding groups of not unusually dangerous teens from society increases their chances to commit future crimes. Misinformation, ideology, and emotional anecdotes, rather than facts or careful analysis, dominated the policy making dialogue around this bill. We can expect nothing but more poor policy and less than optimal services until we use the science available to us to better inform our decisions.

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