

Transforming Adolescent Sex Offender Treatment: Organization-Wide Change Process in a State Residential Juvenile Justice System

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ABSTRACT

A state juvenile justice system underwent a system-wide organizational change process as a result of implementing a new empirically-based residential treatment model for adolescent sex offenders. Because of the significant differences between the new treatment model and the former, the change process required modifications in treatment philosophy and ideology, clinical practice, staff responsibilities and teamwork, and an understanding of applied research and the role of residential juvenile justice providers. A detailed description of the transformative change process is provided and is further examined through the lens of organizational change theory.

KEYWORDS: Juvenile Justice, Adolescent Sex Offenders, Residential Treatment, Organizational Change, Evidence-Based Practice

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INTRODUCTION

The growing body of outcomes literature on adolescent sex offenders (e.g., Calvert & Bauer, 2018; Lussier, et al., 2024; Tidefors, et al., 2019) coupled with significant advances in adolescent brain research over the last two decades (e.g.,

Gardner & Steinberg, 2005; Sowell, et al., 2001; Steinberg, 2005) have forced juvenile justice providers to significantly rethink their approach to treatment. In addition, the increasing push for community-based interventions in lieu of residential placement as well as limits to residential placement to the most serious adolescent offenders (i.e., repeat

offenders, violent offenders, sexual offenders) has resulted in significant reductions in the number of youth in residential treatment. In fact, the number of youth in residential placement nationwide decreased almost 60% between 1997 and 2017, and is currently at its lowest level since data collection began in 1997 (Puzzanchera et al., 2020). There also continues to be increasing calls for the use of evidence-based practices in juvenile justice that has been bolstered by legislative actions, such as California's Juvenile Justice Crime Prevention Act of 2000. Each of these issues has created enormous pressure on juvenile justice providers. This is especially the case for residential treatment providers of adolescent sex offenders.

Further compounding the challenges of residential juvenile justice providers is the empirical knowledge that while adolescent sex offenders are at little risk of sexual offending following treatment, they continue to be at significant risk of non-sexual recidivism. Indeed, with sexual recidivism rates of 3% - 7.2% (Caldwell, 2010; Calleja, 2015; Calvert & Bauer, 2018) and non-sexual recidivism rates of 43.3% - 64.4% among adolescent sex offenders following residential treatment (Caldwell, 2010; McCann & Lussier, 2008; Tidefors et al., 2018), residential treatment may be a primary risk factor related to recidivism for adolescents who have sexually offended.

These issues present significant new challenges for residential treatment providers. Moreover, they come at a time when treatment providers are being forced to contend with overhauling existing sexual offending treatment approaches (i.e., treatment as usual based on adult models) while confronting the long-held ideology upon which such treatment approaches may have been based. As a result, these challenges require significant change by many residential juvenile justice providers—change that may be both comprehensive and transformative.

This article describes in detail the transformative change process that a statewide juvenile justice system underwent as a result of adopting and implementing a new empirically-based treatment model for adolescent sex offenders. The change process that occurred over a two-year period was driven by current research and led by an outside consultant working with a collaborative and diverse staff team. The collaborative team included administrators, managers, clinicians, case managers, and direct care staff. In order to further illuminate the change process and inform other systems considering change, Lewin's (1951) organizational change theory framework is applied.

Treatment of Adolescent Sex Offenders

Despite the significant increase in knowledge of adolescent brain development over the last two decades that clearly delineates the marked differences between adolescents and adults (Gardner & Steinberg, 2005; Luciana, et al., 2023; Steinberg, 2005; Steinberg, 2008), treatment approaches for adolescent sex offenders continue to be largely based on adult treatment models. These models, considered treatment as usual for adolescent sex offender treatment today are cognitive behavioral models that emphasize relapse prevention (e.g., Prenzler, et al., 2023; ter Beek, et al., 2018; Yoder, et al., 2018). Not only have these models continued to proliferate in both the adult and juvenile justice systems, they have done so despite disappointing outcomes research. In fact, the results of two historic outcomes studies failed to establish efficacy for the cognitive behavioral plus relapse prevention model for adult sex offenders (Marques et al., 2005; Schweitzer & Dwyer, 2003). Moreover, because these models do not address the myriad factors related to adolescent sexual offending nor do they take into account developmental differences, there has been speculation that they may result in iatrogenic outcomes for adolescents (e.g., Miller, et al., 2024).

While the continued support for the treatment as usual model with adolescent sex offenders may be somewhat perplexing, it is likely due to a number of complex factors, not least of which is the lack of viable alternatives. Indeed, no specific program to date has established efficacy in significantly reducing overall recidivism for adolescent sex offenders in residential treatment. Further, the results of a recent meta-analysis including both published and unpublished outcomes studies found no difference in recidivism based on treatment type (ter Beek, et al., 2018).

In addition to an absence of effective treatment programs that significantly reduce overall recidivism among adolescent sex offenders, the entrenched nature of the treatment as usual model may further complicate any potential change process. The treatment as usual model was initially designed for adult sex offenders and was based in part on the belief that left untreated, adult sex offenders would continue a pattern of sexually abusive behaviors, committing up to 380 sexual offenses over a lifetime (Barbaree, 1993). This historic belief was informed and reinforced by retrospective studies of adult sex offenders who reported that they had begun offending in adolescence, and led researchers to surmise that adolescent sex offenders would continue a developmental trajectory of continued sexual abuse.

As has been clarified by many since, neither of these beliefs is supported by the literature (e.g., Calvert & Bauer, 2018; McCuish et al, 2015). However, despite the lack of empirical support for such assertions, the mistaken beliefs may have been historically and widely used to indoctrinate juvenile justice professionals as well as those working with adults. In addition, these long-held beliefs have been used to promote sex offender treatment as a specialty area—and as is typically the case with specialties, once established, they are difficult to concede. In

juvenile justice, this has been especially so as demonstrated by the continued emphasis on adolescent sex offenders as a unique group despite significant evidence to the contrary (e.g., Cale, et al., 2016; Chouinard-Thivierge, et al., 2023; ter Beek et al., 2018).

As such, the juvenile justice system has long been entrenched in historic beliefs about the trajectory of sexual offending behaviors and the subsequent manner in which such behaviors must be treated (i.e., treatment as usual) based on beliefs related to adults. In addition, significant federal and state legislation has been enacted specifically to address sexual offenses prompting a fairly continuous stream of federal funding allocations to address sexual offending (e.g., Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART); OJJDP Youth with Sexual Behavioral Problems; OJJDP Supporting Effective Interventions for Youth with Problematic or Illegal Sexual Behaviors). This has resulted in a continuous amplification of sex offenses as arguably the most significant issue in criminal justice, and the issue requiring the most serious and immediate attention. These federal actions have also further promoted the proliferation of sex offense specialists in both the adult and juvenile justice systems. It is against this established backdrop that a state juvenile justice system enacted a significant change process to overhaul their adolescent sex offender treatment program. The change process had to begin with confronting long-held ideologies about sexual offending and work to disentangle the existing foundation in order to successfully change.

Organizational Change

Kurt Lewin is widely considered the founding father of change management, and the architect of what is considered the fundamental approach to managing change (Cummings, et al., 2016). According to Lewin's theory of organizational

change (1951), obstacles or restraining forces allow the status quo to not only continue but to counter positive forces for change despite the need for change. Further, Lewin describes the tension that is established between the push and pull of restraining and driving forces that often results in maintaining a system's equilibrium. As such, in order to effectively change the status quo requires executing a planned change process which is illustrated in Lewin's change model.

Lewin's (1951) planned change model consists of three sequential steps: Unfreeze, change, and refreeze. These steps are described as:

1) Unfreeze relates to creating problem awareness and thereby making it possible for people to let go of old patterns and undo current equilibrium (e.g., educating, challenging status quo, demonstrating issues or problems);

2) Change involves seeking alternatives, demonstrating benefits of change, and decreasing forces that may affect change negatively (e.g., brainstorming, role modeling new ways, coaching, training); and

3) Refreeze requires integrating and stabilizing a new equilibrium into the system so it becomes habitual and as such, becomes resistant to further change (e.g., celebrating success, re-training, and monitoring performance indicators).

To illustrate Lewin's organizational change theory, the theoretical framework is applied to the change process undertaken by the statewide residential juvenile justice system in one of the country's largest and most diverse juvenile justice systems. Each of the change-related activities that was implemented in the juvenile justice system is linked to the corresponding step of the organizational change theory (i.e., unfreezing, change, refreezing) as reflected in the crosswalk (see Table 1). Each of the change-related activities that was conducted are then further described in relation to the change process.

Table 1: *Crosswalk between Lewin's Model of Planned Change and the Change Process Implemented in the Juvenile Justice Setting*

Lewin's Model (1951)	Implemented Change Process
Unfreezing Activities	Unfreezing Activities
Establish the scope of the change process	Formally establish the project scope and timeframe
Challenge and demonstrate problems related to maintaining status quo	Illustrate the existing challenges through data and education
Generate buy-in for change through education and communication	Provide an evidence-based rationale for change with data and research; Provide permission to let go of current ideology
Change Activities	Change Activities
Generate stakeholder engagement	Solicit input on the new treatment model and make modifications; Cement team-based structure in treatment delivery
	Introduce the new treatment model
Coaching and mentoring	Establish a team of change leaders

Lewin's Model (1951)	Implemented Change Process
Implementation	Pilot new model, evaluate the treatment model and implementation process, and make any modifications
	Fully implement the treatment model
Refreezing Activities	Refreezing Activities
Celebrate success	Celebrate success internally; youth testimonials; commemorate success through external stakeholder engagement
Monitor and evaluate	Implement fidelity checklist and team-based monitoring; evaluate treatment model
Retrain and socialize new employees	Retrain/train employees through ongoing training providing Train the Trainer team and implementation of a Facilitator's Manual
Sustain	Sustain new model through dissemination of outcomes

LEWIN'S (1951) CHANGE PROCESS IN ACTION IN A STATEWIDE JUVENILE JUSTICE SETTING

Unfreeze Activities

Formally Establish the Project Scope

A number of factors, including political pressure and poor treatment outcomes led to the initial desire to engage in a significant change process in the statewide juvenile justice system—a change process involving the development and implementation of a new residential treatment program for adolescent sex offenders. The residential juvenile justice system, among the largest in the U.S., included 5 facilities, and at project inception, housing almost 800 youth. Once the decision was made to initiate the change, a team of the system's administrators and managers worked to identify the scope of the project. The scope of the project was then formally established in a detailed written document that outlined the need for

a new treatment model and identified specific parameters related to the project. The project scope included specific deliverables (e.g., training, manuals, consultation) and timeframes for delivery of each, as well as the project timeframe from beginning to completion (i.e., two years).

Illustrate Existing Challenges through Data and Education

In order to structure and lead the change process internally, a task force of supervisors and managers was created. Each level of staffing was represented by several members on the task force ensuring adequate participation across all levels, including from each facility and each unit. The task force was charged with structuring the change process before initiating change, which also helped to promote internal buy-in for change. Task force members also served as liaisons between their respective factions (e.g., direct care, security, management) and the team, ensuring the voices of each faction were

effectively heard while serving as informal change leaders to their colleagues.

Following an official public call for proposals in accordance with governmental funding opportunities, an external consultant was selected to develop and implement the new adolescent sex offender treatment program. The consultant worked directly with the task force, systematically leading the group through each of the unfreezing activities in order to prepare the system for change. The unfreezing process began with clearly illustrating the problem through detailed data and information about the existing treatment program and its related outcomes. Most significant among these data was the primary treatment outcome of recidivism among the division's adolescent sex offenders. The recidivism rate had continued to significantly increase over the years for these adolescents as well as for the rest of the system's adolescent offender population with levels higher than 45%. The recidivism data was published regularly and was also fairly well-publicized since the juvenile justice division was part of the state system. In addition, the system's outcome data had been the source of scholarly articles, some of which further emphasized the problematic nature of the outcomes (e.g., Barnert, et al., 2017; Lin & Janetta, 2006).

In addition to the negative recidivism data, the juvenile justice system was under significant scrutiny as the source of an ongoing lawsuit. The lawsuit, that had been filed in 2004, was a class action suit requiring significant changes across the entire juvenile justice system. Specific issues related specifically to the adolescent sex offender treatment program identified in the suit included inconsistencies in treatment delivery across units and inconsistencies in staff training and competencies.

The consultant facilitated presentations highlighting the negative treatment outcomes and treatment delivery problems to further illustrate the issues impacting the existing adolescent sex offender

treatment program. These presentations prompted detailed discussion among the task force about the need for a change, and served to further educate task force members about the myriad issues facing the system.

Provide an Evidence-Based Rationale for Change

Examining the existing challenges and problems through a data-driven process provided initial momentum towards the unfreezing process. It was then immediately followed by an in-depth review of the extant research on adolescent sex offenders. This review of current literature was facilitated through a series of educational sessions in which current empirical data related to adolescent sex offending, treatment methods, and outcomes was reviewed and discussed. Because a substantial body of empirical outcomes data on adolescent sex offenders now clearly established the very low rate of sexual recidivism (e.g., Caldwell, 2010; Chu & Thomas, 2010; Hargreaves & Francis, 2014; Tidefors, et al., 2019), these current findings were in direct conflict with the premise upon which the system's existing treatment model had been based. These contradictions were specifically emphasized through facilitated discussion.

Task force members were able to confront their own contradictory beliefs and past knowledge of adolescent sex offenders by learning about current empirical findings. Task force members were then able to critically evaluate the significant problems facing their current treatment model as well as the ideology upon which it had been established in comparison to the current empirically-based knowledge about adolescent sex offending. This process of critical examination and learning provided an opportunity for task force members to not only understand but to begin to support and build an evidence-based rationale for change.

Permit Letting Go of Existing Model and Ideology

The juvenile justice system had a long history of providing adolescent sex offender treatment, as well as, a workforce of a large, committed group of long-term employees. In addition, the existing treatment program had been implemented for several years, and staff had long been indoctrinated to the model. As a result, staff members vocalized their strong belief and commitment to the existing treatment model, articulating exactly how it functioned and the roles that various staff members played.

Providing an evidence-based rationale for change was therefore critical to opening up discussions around change that didn't leave staff members feeling as though their previous work had been futile. In order to do this, it was important to acknowledge that few other juvenile justice systems had yet to modify their approaches to adolescent sex offender treatment despite the current research. In addition, significant time (i.e., weeks) was devoted to emphasizing the widespread and historic acceptance and support for the existing treatment model—a model based on adult sex offender treatment. This served to ensure that no blame was placed on staff members or the particular juvenile justice system for continued use of the existing treatment model. It also served as permission for staff members to begin letting go of past ideology tied to the existing treatment model.

Change Activities

Solicit Input and Make Modifications

The existing treatment model had been in place for more than a decade with some significant aspects of the model dating back to the 1980s. Staff members could recount individual stories of success they had witnessed throughout the years—stories that they attributed to the existing treatment model.

In order to continue the change process, it was essential that staff develop ownership of the new treatment model. As such, specific input and feedback was solicited about the development of the new treatment model. Whereas it was made clear that such input could not conflict with the evidence-basis of a new model, providing staff a voice in the modification of procedural aspects and specific activities was critical given the degree of investment many staff had in the existing model and its ideological foundations. In addition, where possible, a small number of aspects from the existing model were able to be retained in the new model—further supporting an easier transition while providing some continuity in the treatment model.

In addition to ensuring staff participation in the change process, input was also solicited from adolescents participating in the existing treatment. To gather input, a number of methods were used including surveys, focus groups and individual discussions. These discussions focused on treatment-related aspects such as treatment delivery methods (i.e., individual, group, family-based), areas that adolescents felt were missing from residential life, type and schedule of activities, and rules and structure, among other issues. Similar to input gleaned from staff, the act of soliciting and using some input from adolescents was essential to preparing the system for change. While adolescent input provided critical data to the treatment development process, it also enhanced the developmentally-informed nature of the new treatment model.

Cement Team-Based Structure in Treatment Delivery

The juvenile justice system had historically been committed to an interdisciplinary team approach to treatment delivery, however, this was in some cases, more theoretical, than practical. For instance, in significant aspects of the existing treatment model,

only specific staff members participated in the treatment delivery and decision-making processes. As such, much of the treatment was delivered in an isolated manner by just one group of staff. Further, there was little clarity related to how and when other staff could participate in treatment delivery, goal development or treatment goal evaluation.

Therefore, it was important to ensure that staff from various staff levels would each participate in delivery of the new treatment model. In addition, it was important that this be designed systematically with specific protocols embedded in the new treatment to ensure that a team-based approach was fully integrated in the design. While the interdisciplinary team approach promoted group buy-in to the change process and the resulting new treatment model, it also promoted shared responsibility for each adolescent's treatment.

Specific staff levels were assigned to various aspects of treatment delivery, allowing individuals from each staffing level to leverage their unique strengths and connect with adolescents across the treatment process. For example, case managers were responsible for leading all reentry-related activities while youth workers facilitated specific individual exercises with adolescents. In addition, each member of the inter-disciplinary team had an equal voice in providing input on individual treatment progress, and in treatment planning decisions. This degree of treatment team involvement was designed to create a culture of teamwork through shared responsibility, and further engage each staff member to the new treatment model.

Introduce the New Treatment Model

Given the prominence of the team-based structure in the new treatment model design, training in the new model was facilitated by unit with each unit's full staff team participating in the training. This not only provided the initial opportunity for each unit team to engage collectively with the new model, but also to problem-solve around potential implement-

tation challenges and to further collaborate on the implementation plan.

In addition to introducing the new treatment model to all staff, it was also important to introduce the model to all youth. To accomplish this, large group meetings were conducted with youth on each unit to provide information about the new treatment model, discuss the pilot implementation process, answer questions, and provide clarification. These youth information sessions were intended to create a safe space to allow for any concerns to be discussed. In addition, these information sessions were designed to prepare youth for the change process and promote inclusion in the process.

Establish a Team of Change Leaders

Because the task force had already been composed of supervisors and managers from each staffing level, the task force served as change leaders for and to each of their respective factions. As such, task force meetings were structured to discuss and approve changes related to the new treatment model and the implementation process, often spurring vigorous discussion and debate. Task force members agreed that while difficult discussions would likely occur during task force meetings, that communication and direction outside of the meetings would be consistent. This type of unity was critical to promote buy-in throughout the change process and to ensure that there was top-down support of the change process from all levels of staff. In addition, task force members were able to more effectively support one another as each sought to address specific questions and concerns among their respective staff groups.

Pilot New Model

Given the scope of the new treatment model and significant change that the model required, it was imperative to conduct a pilot implementation. The pilot was necessary to both effectively test out various aspects of the model and to inform the

subsequent full implementation process. To do this, the new treatment model was implemented in both of the system's units dedicated to adolescents with sexual behavior problems.

The pilot implementation afforded an opportunity to assess and ensure that the treatment model was easily and fully comprehended by both staff and youth. As such, the instructions guiding treatment delivery and all clinical activities were assessed to ensure they were clear and able to be implemented as designed.

During the pilot process, youth were particularly concerned that the new treatment may not be able to help them as much as they had thought the previous one did. During the feedback process, it was revealed that some youth—similar to staff—had attributed successful treatment to aspects that were not empirically supported. Chief among these was a requirement in the existing model that youth must continuously repeat the details of their crime(s) in order to prevent reoffending.

The new treatment model emphasized the development of enhanced decision-making skills and the acquisition of new behaviors opposed to emphasizing past behaviors. Despite providing thorough explanations and discussing specific research, several youth had difficulty understanding that repeating such disclosure did not promote new skills for a healthy life or equip them to make better choices. This particular issue brought to the fore just how much the ideology of the former treatment model had been entrenched in not only staff but in youth as well. As such, it provided essential information to the task force and staff about the need for additional preparatory work to undo any false beliefs associated with the former treatment so that both staff and youth would be able to effectively work with the new treatment.

Following the pilot implementation, revisions were made to the treatment model, specifically to better clarify instructions for treatment delivery and instructions for treatment-related activities. In addition, more time was devoted to further educating youth and staff about various components of the new treatment model and the associated rationale and further explaining and justifying why specific elements of the former treatment would no longer be used.

Fully Implement the New Treatment Model

Each of the activities conducted prior to implementing the new treatment model was essential to establishing an appropriate foundation. In addition, piloting the new treatment model in order to identify any challenges and resolve them through providing additional preparatory activities and/or completing final adjustments to the model was similarly critical to ensuring a successful implementation.

A launch date was scheduled and on that date, the new treatment program was fully implemented in each adolescent sex offender treatment unit. The date was widely publicized to both further prepare everyone for implementation and to commemorate the significance of the day—a day that would officially mark the end of the former treatment model and the beginning of a new treatment model and process across the juvenile justice division.

Refreezing Activities

Celebrate Success

Enacting system wide change can often be difficult at best, particularly when doing so within large public systems. It is also at times easy to get so lost in the details of the change process that achievements and important milestones may go unrecognized. Missing such opportunity to acknowledge the change process can threaten the

long-term sustainability of the change, so it is vital that the wins are acknowledged and celebrated.

Celebrating the change process was accomplished through a variety of methods, including during staff meetings and large staff gatherings, during small youth groups and large youth group forums, and publicizing the change process to inform all stakeholders. It was important that both the completion of the change process (i.e., new treatment model implementation) was noted as part of the celebrations but also that data related to the change process was also shared to fully convey the transformative nature of the change. In this case, this meant widely sharing the findings of the initial quality assurance reviews illustrating success in attaining specific change-related performance measures.

On a more significant level, the success of the change process resulted in the end of the long-standing lawsuit. The end of the lawsuit provided not only a highly meaningful outcome reflecting the successful change process, but also one that had historically felt intractable. Highlighting the end of the lawsuit and its direct connection to the successful change process significantly reinforced the purpose of the change process, and provided another opportunity for acknowledging the collective work that had led to the successful change. As such, it was imperative that all participating staff fully acknowledge and celebrate their hard won success (i.e., lawsuit resolution). It also allowed staff and stakeholders to feel even greater ownership of the new treatment model, and provided further momentum to continue working towards sustained change.

As part of the effort to celebrate the successful change process with external stakeholders, including both governmental officials and plaintiffs of the initial lawsuit and their attorneys, as well as court representatives (i.e., jurists, parole board members), a meeting was held to mark the full implementation

of the new treatment model. In the meeting, a video was shared highlighting both the new treatment model in action along with personal testimonies from participating youth about the new treatment model. This meeting between juvenile justice division staff and influential stakeholders resulted in a powerful and emotional experience, particularly among the external stakeholders. It also provided yet another reminder of the broad degree of impact the change itself held.

Implement Fidelity Checklist and Team-Based Monitoring

To ensure that the integrity of the new treatment model could be effectively maintained both initially and well into the future, a comprehensive treatment facilitator's manual was developed. The facilitator's manual provided step by step instructions to guide each treatment activity, including scripts for participating staff to use and detailed information about specific interventions. In addition, complete curricula were included in the facilitator's manual to guide multi-week group therapy interventions focused on specific topics (e.g., affective development).

In addition to the facilitator's manual, a fidelity checklist and quality assurance monitoring plan was also developed. These tools were designed to guide ongoing fidelity assessment activities. Because the new treatment model was designed as a team-based model, it was imperative that ongoing program monitoring be led directly by team members and conducted in an inter-disciplinary manner. To ensure this, fidelity checklists were included in the facilitator's manual that were designed to be completed collectively by all treatment team members.

Evaluate Treatment Model

Whereas maintaining treatment fidelity was integral to effective implementation of the new treatment model, evaluating treatment outcomes was impera-

tive to understanding the effects of the new model. Because the new treatment model was implemented in a governmental juvenile justice system, treatment outcome data continued to be routinely collected, analyzed and publicly disseminated. Once the initial full year of treatment outcome data had been collected and publicly disseminated, it was important that the data be specifically shared with all staff and stakeholders and openly discussed in order to effectively connect the outcomes data to the change process. Both informal and formal meetings were held with staff to do this—further reinforcing the change process, and the results of the collective team efforts.

In order to further evaluate the impact of the change process, an analysis of the recidivism data was also conducted to investigate differences before implementation of the new model and following (i.e., comparison of treatment outcomes based upon treatment model) (see Calleja, 2022). This provided increased objectivity related to understanding the treatment outcomes while also providing for a more sophisticated statistical analysis.

Training and Retraining

The facilitator's manual was a critical tool to ensuring the fidelity of the treatment model over the long-term, and an essential resource to provide ongoing clarity to issues that arose during implementation. As a result, the facilitator's manual was integral to initial implementation, refresher training, and new staff training.

New policies and procedures related to staff training expectations and requirements were also implemented to ensure treatment fidelity. For instance, all new staff were required to complete treatment program training within thirty days of employment, while all staff were required to participate in annual refresher training. In addition, ad hoc training on specific issues was incorporated

as a regular agenda item into staff and treatment team meetings.

Finally, it was deemed essential that the task force continue to be in place long beyond implementation. As such, the task force continued to meet regularly and assess various aspects of implementation to prevent against future loss of treatment fidelity. When specific problems or challenges are identified, the task force coordinates training to address deficiencies. This ongoing level of oversight has not only been vital to maintaining the fidelity of the model but has also helped to sustain the treatment culture for both staff and youth.

Sustain New Model through Dissemination of Outcomes

The initial outcomes data indicated a significant reduction in recidivism (29.4 % from 48.3%) from the previous several years related to the former treatment model (California Department of Corrections and Rehabilitation, 2019). In addition to sharing the outcome data with staff, youth, and internal stakeholders, it was also imperative that it be shared with external stakeholders and that it be more broadly publicized.

The outcomes data was made publicly available on the juvenile justice division's website, and has been regularly and publicly referenced by the division's executive leaders. In addition, an effectiveness evaluation comparing the former treatment model and the new treatment model has been published elsewhere (see Calleja, 2022), and has also been referenced as part of not only sustainability efforts but also as an addition to the body of treatment outcome literature.

IMPLICATIONS FOR JUVENILE JUSTICE AND FUTURE RESEARCH

Organizational change often poses a daunting task, and the more entrenched a system is in its current operations, the more challenging the change process can be. This was certainly the case with the state's residential treatment program for adolescent sex offenders examined in this article. However, given the successful change process that the statewide juvenile justice division was able to accomplish, these efforts may offer guidance for other governmental and non-governmental juvenile justice providers about how they too may engage in large-scale organizational change.

Moreover, because of the need for many juvenile justice providers to reconcile treatment approaches for adolescent sex offenders with current research, the change process discussed herein may be particularly instructive. This may be especially true for providers that are continuing to use treatment as usual models and/or that recognize the need for a significant change in the treatment approach.

While this particular change process was successful as measured by a complete and effective transition to implementing a new treatment model within established timeframes, the change process was supported by significant financial resources. This may often not be the case in juvenile justice, and as a result, a lack of financial and other resources may hinder successful change.

In addition, whereas this change process resulted in significant successful treatment outcomes, that may certainly not be the case with all change processes. As a result, it is imperative that organizational change efforts are undertaken in response to needed change—the outcomes of which then must be evaluated. And, more importantly, with the understanding that an effective organizational change process does not necessarily equate to effective organizational outcomes but without

effective organizational change, organizations can rarely, if ever, effectively transition to the implementation of new treatment models.

Juvenile justice and the manner in which various aspects of the juvenile justice system operate have implications for numerous stakeholders, including but not limited to government officials, treatment providers, adolescents and their families, and the public. As a result, efforts to document and disseminate knowledge of all change efforts that may impact juvenile justice should continue to be encouraged. In addition, further research should be conducted to evaluate the long-term outcomes related to organizational change efforts.

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DECLARATION OF INTEREST

Authors report no known conflict of interests to disclose. Nancy Calleja was the Project Director and consultant who developed the new treatment program that was part of the change process discussed in the article and Heather Bowlds was the internal project lead on the new program implementation.

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