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**Juvenile Sex
Offender Treatment**

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3/28/2019**

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

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The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Problematic sexualized behaviors in adolescents (ages 12-17) can be defined as behaviors involving sexual actions that are developmentally inappropriate and may cause harm to others. These sexual behaviors may be based on coercive, intrusive, or abusive actions toward another person. Adolescents with problematic sexualized behaviors may violate the rights of others based on what appears to be sexually motivated desires or impulses. This behavior may or may not be motivated by sexual desires. Sexualized behaviors resulting in police involvement or criminal charges may include lewd conduct (e.g., public nudity, masturbation), incest, molestation, sexual
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assault, or rape.¹ Youth who have engaged in sexual offending behavior are a less heterogeneous group than youth with sexual behavior problems, but there is currently no profile for the population. While the information available on juvenile sex offenders is limited (in comparison to the adult population), research in the area has grown and we know more about rates and treatment than in previous years. In addition:¹

- Juvenile sex offenders tend to have similar family factors (e.g., histories of physical abuse, family disruptions, harsh/inconsistent discipline, low parental monitoring/supervision)
- Delinquent youth may have deviant peer associations and significant school problems; however, there are youth who commit sexual offenses who may not present with these issues
- Younger ages of offending are associated with higher risk of re-offending
- Adolescent males tend to be identified more than adolescent females with problematic sexual behaviors; however, females are being increasingly identified according to arrest records
- Approximately 8-9% youth report experiencing sexual victimization (associated with risk of re-offending)
- Based on reported crimes, sexual recidivism rates range from 7-13% of juvenile sexual offenders; recidivism rates are much lower for youth than for adult sexual offenders, emphasizing the importance of early intervention

Juveniles are responsible for a significant proportion of sexual violence, with official records indicating that minors account for 17% to 20% of all sexual crimes except prostitution, and victim reports and youth self-reports suggesting even higher rates of youthful sexual offending. The annual costs associated with sexual victimization in the United States are estimated to be between 8 and 26 billion dollars. Social and fiscal costs are also borne by sexual offenders, many of whom are removed from their families and placed in confinement for years and then required to publicly register for their offenses, often for 25 years to life.² **There has been an almost complete lack of rigorous research on effective interventions for juvenile sexual offenders, specifically regarding the widespread use of unproven interventions for this population.**

Dominant interventions (e.g., cognitive-behavioral group treatments that emphasize relapse prevention) fail to address the multiple determinants of juvenile sexual offending – these could result in iatrogenic outcomes. In addition, there are concerns that existing treatments are largely ineffective. Effective interventions are needed for offending youth to reduce sexual victimization and to increase the likelihood that such youth can become law-abiding and productive citizens. The development of effective interventions for juveniles who sexually offend requires an understanding of the correlates and causes of sexual offending in youths. Existing research and literature indicates that multiple characteristics of individual youths and their social systems are linked with juvenile sexual offending; these characteristics can be viewed within a socioecological framework that views youths as embedded within increasingly complex systems, including family, peers, and school.²

Professional associations such as the American Medical Association (AMA) and the American Psychological Association (APA) have also advocated for the utilization of scientific research to guide practice and policy.² **It is generally preferable to conduct the clinical evaluation after adjudication.**

Practice Parameters published by the American Academy of Child and Adolescent Psychiatry (AACAP) list key items that professionals should learn from the clinical interview:³

- Degree of cooperation
- Honesty and forthrightness of the abuser
- Degree of acceptance of responsibility for his or her sexual offenses
- Degree of remorse and regret
- Relationship between the abuser and the victim
- Age difference between the abuser and the victim
- Characteristics of the sexually aggressive behavior
- Frequency and duration of the sexually aggressive behavior
- Precipitating factors that led to the sexual offense
- Premeditated or impulsive

- Characteristics of the victim that attracted the offender
- Nature and extent of the coercive behaviors
- Behaviors before, during, and after the sexual offense
- Affect states before, during, and after the sexual offense
- Verbal interchange with the victim
- Attempts to avoid detection
- Understanding of the effects of his or her sexual behavior on the victim
- Insight into the wrongfulness of his or her sexual behavior
- Understanding of the consequences of the behavior

Available empirically-guided assessment tools for adolescents include:¹

- Adolescent Sexual Interest Card Sort
- Multiphasic Sex Inventory Adolescent Version
- Child Sexual Behavior Inventory
- Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0 (ERASOR)
- Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)
- Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II)

Treatment Planning

Current treatments focus heavily on presumed psychosocial deficits in the individual youth. In addition, predominant approaches to treatment is the fact that many sexually offending youths desist from future offending (even in the absence of intervention); this issue has also been raised regarding the relapse prevention (RP) model used with adult offenders.²

Considerations in evaluating the risk of further sexual offenses include the frequency and diversity of the sexual offenses, the severity of the aggressive-sadistic behavior, the playfulness/impulsivity of the sexual offending behavior, psychopathology, neurological impairment, prior antisocial or violent behavior, motivation for treatment, intelligence, psychological mindedness, capacity for empathy, and family, community, and social support.³

Factors to consider for placement in a more restrictive environment include the consistent need to deny sexual offenses, the lack of remorse and victim empathy, a well-established pattern of frequent and diverse committed acts of sexual aggression, the number of previous arrests, the number of victims, severity of psychopathology, failure of previous treatment efforts, the degree of compulsivity and sexual arousal, and a documented history of violent aggressive and sadistic behavior.³

The first task is to protect the community. The cost of providing specialized outpatient treatment was about one fifteenth of the cost that one would have to provide in an institutional or residential setting. A significant percentage of juvenile sexual abusers will respond to therapeutic intervention. Little is known about the natural course of untreated juvenile sexual offending behavior. The estimated recidivism rate for untreated sexual abusers is 40%; one small study of adolescent severe sex offenders found that 37% had sexually reoffended and that 89% continued to commit other acts of violence. The general consensus is that the recidivism rate for adolescent sex offenders in treatment programs is 5% to 15%.³

There are several explanations as to why the adolescent offender may be more amenable to treatment than the adult sex offender:

- The adolescent offender's deviant pattern of sexual offending behavior is less deeply ingrained.
- The adolescent is still exploring alternative pathways to sexual gratification.
- The adolescent's central masturbatory fantasy is still evolving and is not fully consolidated.
- The adolescent is available for learning more effective interpersonal and social skills.

Treatability depends on a number of patient characteristics and situational factors:

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- Level of understanding of the seriousness of the offense
- Motivation to discuss and understand the offense
- Capacity for empathy and human relatedness
- Severity of psychopathology
- Entrenchment of deviant sexual arousal patterns
- Type and frequency of sexual offending behavior
- Aggressiveness of the sexual offense
- Degree of characterological impairment
- Nature of the treatment program

Goals that professionals should focus on while treating a juvenile sex offender includes: ³

- Confronting the offender's denial.
- Decreasing deviant sexual arousal.
- Facilitating the development of non-deviant sexual interests.
- Promoting victim empathy.
- Enhancing social and interpersonal skills.
- Assisting with values clarification.
- Clarifying cognitive distortions.
- Teaching the juvenile to recognize the internal and external antecedents of the sexual offending behavior.

Individual therapy is usually used in conjunction with other treatment approaches and probably should never be relied on as the only treatment modality. Individual therapy may be the treatment of choice for the younger, sexually reactive abused child who has become sexually abusive. This is particularly true for children who manifest high levels of intrapsychic conflict, emotional distress, confusion, and defensiveness around their own sexual victimization.³

Types of Therapy

The main types of therapy used for treating juveniles are highlighted below: ⁴

Functional Family Therapy (FFT)

The primary emphasis of Functional Family Therapy (FFT) is on the dynamics and structure within the family unit.²² A key goal is to enhance the ability of the parents or caregivers to provide adequate structure, limits, discipline, and support. FFT has been used for over thirty years with delinquent youth and their families, and the research has consistently demonstrated that youth who participate in FFT have significantly lower rates of recidivism relative to comparison groups of youth receiving other interventions, such as individual therapy. In fact, researchers have found that FFT reduces recidivism by as much as 25 percent.²³ Because it is a relatively short-term intervention with low costs, FFT certainly appears to be a very cost-effective approach that “works” with juveniles.⁴

Multisystemic Therapy

Multisystemic Therapy (MST) is similar to Functional Family Therapy (FFT) – it is an intensive, family-based treatment approach that is designed to address the multiple factors that are associated with delinquent or antisocial behavior, including individual, family, peer, and community influences. Treatment plans are developed collaboratively between the family and the treatment provider. MST interventions are delivered in the youth's natural environment: home, school, and community. This is important so that youth and their families learn to effectively function and become autonomous.⁴

Common goals for MST include improving family functioning, enhancing parenting skills, increasing the youth's associations with prosocial peers, improving school performance, and building upon community supports.

Research indicates that these and other positive goals are often attained in a cost-effective manner; and that recidivism rates of youth are reduced by more than 30 percent.⁴ Research has shown significantly fewer youths in MST were rearrested for sexual crimes (12.5% vs. 75.0%) and the mean frequency of sexual rearrests was considerably lower in the MST condition (0.12 vs. 1.62). The mean frequency of rearrests for nonsexual crimes was lower for the youths who received MST (0.62) than for counterparts who received outpatient therapy (2.25).²

Group Therapy

The most common treatment modality is the use of groups, with up to ten youth per group. Some groups are more traditional “therapy” groups, in which specially-trained mental health professionals use specific therapeutic techniques, strategies, and processes, and the dynamics of the group as a whole, as a means of addressing clinical issues. Other groups are psychoeducational with a facilitator (who may or may not be a mental health professional) provides instruction about specific topics or issues to the group. Group members are often expected to relate to their own circumstances the information which is being “taught,” making the group more didactic in nature. This approach appears more like classroom instruction than a group therapy session.⁴

Individual and Family Therapy

Professionals generally agree that treatment should also include individual and family therapy for several reasons:⁴

- If treatment programs truly intend to be individualized, holistic, and comprehensive, it is probably unreasonable to believe that the range of needs of each youth can be adequately addressed within a group setting. The time factor alone must be considered. For example, given the number of participants in a group, it is hard to imagine that each youth will have sufficient time on a week-to-week basis to process all that they need to.
- Some issues may be too sensitive to discuss initially (if at all) within a group setting. This includes discussion of youth’s own victimization or his or her struggles with sexual identity as well as certain types of family problems and dynamics that cannot be addressed effectively in the treatment groups.
- Responsivity factors may impact the ability of some youth to respond to the group format, or may not lend themselves to being addressed in a group. For example, for youth who have co-occurring mental health difficulties, these needs may be more effectively addressed outside of the group, as the group tends to be geared toward the common issues and needs of all of the group members.
- Some youth simply may not respond to a group format (e.g., emotional immaturity; considerable behavioral disturbance; level of intellectual or cognitive functioning may limit the ability to understand, contribute to, or “keep up with” the group members and process).
- Concerns of the potential negative impact that may arise when aggregating delinquent youth for the purpose of intervention. Professionals may elect not to include certain youth in certain types of treatment groups, if they choose to use groups as a means of intervention at all.

Specific Psychoeducational Modules

Psychoeducational modules are didactic experiences that provide sexual abusers with information about sexuality, sexual deviancy, cognitive distortions, and interpersonal and social behaviors, as well as strategies for coping with aggressive and sexual impulses and anger management. A summary of modules is below:³

- **Victim Awareness/Empathy.** The focus is on understanding the effects of sexual assault on the victim, identifying cognitive distortions and myths that support the sexual assault, and promoting participation in therapeutic endeavors.

- **Values Clarification.** The therapist clarifies sexual values as they relate to the cessation of exploitative sexual relationships.
- **Cognitive Restructuring.** This is an attempt to correct the cognitive distortions and the irrational beliefs that support the sexual offending behavior and to replace them with reality focused and culturally acceptable beliefs.
- **Anger Management.** Instruction is provided to facilitate the recognition and the development of appropriate coping strategies for managing anger.
- **Assertiveness Training.** Training is provided to promote more appropriate self-assertive behavior to have one's needs satisfied in a reality-oriented and culturally acceptable manner.
- **Social Skills Training.** The therapist facilitates more effective prosocial behaviors, communication skills, and interpersonal awareness.
- **Sexual Education.** The therapist provides information regarding human sexuality, myths, sex roles, and variations of sexual behaviors.
- **Stress Reduction/Relaxation Management.** Techniques for coping and reducing stress, anxiety, and frustration are made available to the group.
- **Autobiographical Awareness.** Emphasis is on the individual developing an understanding of his or her own life trajectory and how the pattern of sexual offending behavior evolved over time.

Comorbid Disorders

The most prevalent comorbid psychiatric disorders are conduct disorder, 45% to 80%; mood disorders, 35% to 50%; anxiety disorders, 30% to 50%; substance abuse, 20% to 30%; and attention-deficit hyperactivity disorder, 10% to 20%. Research shows that the younger the child when his or her first sexual offense was committed, the higher the number of coexisting psychiatric diagnoses. In addition, studies have found that approximately 40% to 80% of juvenile sex offenders manifest learning disabilities and behavior problems in school.³

Psychopharmacological Interventions

Selective serotonin reuptake inhibitors (SSRIs) have been shown to have an impact on sexual drive, arousal, and sexual preoccupations. Fluoxetine has been the agent most studied, and there are a number of reports indicating that its use is associated with a reduction in paraphiliac behavior and nonparaphiliac sexual obsessions.³ The antiandrogen drugs are reserved for the most severe sexual abusers and are generally discouraged for use in adolescents younger than 17 years of age. Antiandrogen medications should never be used as an exclusive treatment for paraphiliac and aggressive sexual behavior.³

Treatment and Recovery Challenges

The AACAP stress that professionals need to take into account that cognitive development is not fixed or stable, and some evidence-based treatment utilized for adult populations may not be appropriate or effective for adolescents. Examples of interventions that are considered controversial or those not accepted as standard of practice with juveniles include: ¹

- Arousal assessment (e.g., plethysmograph/phallometric assessment)
- Aversive conditioning
- Relapse prevention
- Shame techniques
- Interventions lacking the involvement of parents
- Polygraph
- Hormone Replacement: Anti-androgen

Juvenile Sex Offender by Age Group³

A history of sexual abuse is more prevalent in sexual abusers than in the general population and in nonsexual abusers. Reports of sexual victimization in the history of adolescent sex offenders vary from 19% to 82%.

The Preadolescent Sex Abuser. There is increasing awareness that children younger than 12 years of age may be sexually abusive toward other children. In these cases it is necessary to discriminate between age-appropriate sexual exploration and sexually abusive behavior. The term sexually reactive refers to children who display sexually inappropriate behavior in response to sexual abuse or exposure to explicit sexual stimuli. This population has been characterized as often exhibiting impulsivity, anger, fear, loneliness, confusion, depression, obsessional and compulsive preoccupation with sex, excessive sexualization, anxiety, and sleep disturbance.

The Adolescent Sex Abuser³. Four types of sexual abusers have been identified, with most offenders combining features of each:

- The true paraphiliac with a well-established deviant pattern of sexual arousal.
- The antisocial youth whose sexual offending behavior is but one facet of his or her opportunistically exploiting others.
- The adolescent compromised by a psychiatric or neurological biological substrate disorder which interferes with his or her ability to regulate and modulate aggressive and sexual impulses.
- The youth whose impaired social and interpersonal skills result in turning to younger children for sexual gratification unavailable from peer groups.

Personality Characteristics. Adult sex offenders frequently manifest significant personality disturbances. In an effort to explicate personality traits and character pathology, using a structured psychiatric interview, examined a population of adolescent sex offenders in a residential center. They found a high prevalence of severe personality traits including narcissistic, borderline, and conduct-disordered behaviors. Ninety-two percent of the boys met criteria for a diagnosis of conduct disorder; 67%, narcissistic personality disorder; and 72%, borderline personality disorder. The younger the age of onset of sexual offending behavior and the younger the sex offender was at the time of his or her own sexual victimization, the more likely he or she was to exhibit symptoms of a borderline personality. The high prevalence of narcissistic and borderline psychopathology is consistent with histories of severe emotional, physical, and sexual abuse. Another study found that adolescent sex abusers who offended against children were more schizoid, dependent, and avoidant than adolescents who sexually abused peers.³

The Female Juvenile Sex Abuser. It is known, however, that 50% to 95% of female sexual abusers report a history of sexual victimization. Female juvenile offenders are more likely to have been sexually abused at a younger age and to have had multiple abusers and are 3 times more likely to have been sexually abused by a female. Approximately 70% of the offenses took place while the offender was baby-sitting. The mean age of the victims was 5.2 years. Fourteen (50%) of the offenders had a history of being sexually abused.³

The Developmentally Disabled Juvenile Sex Abuser. Special consideration should be given to juvenile sex abusers with developmental disabilities. Research found that 50% had engaged in problem sexual behaviors and that independent of a history of sexual abuse, low verbal IQ was correlated with sexually inappropriate behaviors.³

POSITION STATEMENT

Applicable To:

- Medicaid
- Medicaid – Florida (CMS Health Plan - CHIP)

Exclusions

Any of the following guidelines may be sufficient for exclusion from this level of care:

- The patient is actively suicidal or homicidal.
- The patient has a physical or psychiatric condition requiring stabilization prior to receiving treatment.
- The patient is suffering from an acute chemical dependency condition that precludes initiating treatment.

In addition, services **are not covered** when the member meets any of the following:

- Felony charges pending that would pose a danger to other patients.
- Behaviors that do not require an inpatient setting for treatment as per Best Practices documentation.
- Behaviors that may put other patients at risk.
- Active involvement with the juvenile justice system where mental health services can be as appropriately accessed.
- Members whose cognitive function is severe enough to prohibit the services from being of benefit.
- Diagnosis of a developmental disability where Applied Behavioral Analysis (ABA) services are required.
- Parental refusal to accept the child home from acute care or any other less restrictive environment of care and where services would be primarily for the convenience of parents, and custodial in nature.
- Cases where there has been no trial and failure of less restrictive environments and the child can be safely treated in such levels of care including:
 - Therapeutic foster care (e.g., where the child is in State custody).
 - Where available therapeutic group home that are as close, or closer, to the family home and where family dysfunction and family interventions, appear to be a key issue in the child's treatment and recovery.

Coverage

Admission Guidelines

All of the following criteria are necessary for admission to the level of care:

- Current psychiatric and psychosocial assessment with the current DSM diagnosis.
- The individual has engaged in an act of sexual abuse to another individual within the past 90 days (or more, if delay occurs due to delayed discovery or legal system.) or patient has a history of having committed a sexual offense, is in outpatient treatment, and is demonstrating behavior suggesting to the treating clinician that new offending behavior is imminent.
- Treatment services can reasonably be expected to improve the youth's condition.
- A risk assessment with a structured instrument (e.g., J-RAT or CI/JRAT) and clinical interview by a licensed clinician and trained specific to sexual offending classifies the youth as moderate or high risk to offend.
- A residential level of care is recommended by a licensed clinician referenced in #4, and a less intensive level of care is contraindicated due to level of risk of re-offending or co-occurring psychiatric disorder

Continued Stay Guidelines

All of the following are necessary:

- The youth continues to be classified as a high or moderate risk based on current risk and assessment of progress toward relevant measurable goals. If other than high or moderate risk as determined by the treatment team and assessment tools, there must be clinical information justifying continued treatment at residential level.
- Available community resources do not meet current treatment needs of individual.
- Continued treatment is likely to improve the patient's condition as demonstrated by progress towards meeting treatment plan goals.
- Treatment plan is updated no less than every 30 days and includes goals which address the impediments which preclude a lower level of care.
- A risk factor and progress assessment is completed no less than every 30 days based on current functioning.
- If present, medication review, management and response are documented.
- A discharge plan identifies specific requirements of aftercare plans which will support transition to lower levels of care after release. An initial discharge plan must be completed within 7 days of admission.

Regular review of this plan must occur during the stay. The discharge plan must be concrete, completed, and confirmed with the member, the member's family, and follow-up providers within 3 – 7 days of discharge.

- Patient may not meet all the above criteria, but is in the process of an active transition to a community level of care.
- Services, ALL
- Psychiatric evaluation at least 2x/wk
- Clinical assessment at least 1x/wk
- Individual/Group/Family therapy at least 5x/wk
- Behavioral Contract/Symptom management plan
- School/vocational program

NOTE: Continued risk assessment should be based on assessment of clinical staff, progress on treatment goals, and dynamic risk factors, as well as use of an assessment tool such as the J-RAT Interim Re-Assessment.

CODING

CPT®* Codes – No applicable codes.

HCPCS Codes – No applicable codes.

Covered ICD-10-CM Diagnosis Codes

F65.9 Paraphilia
T74.22xA-T74.22xS Child sexual abuse, confirmed

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal/ state laws.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
3/28/2019, 3/1/2018, 4/6/2017	<ul style="list-style-type: none"> • Approved by MPC. No changes.
3/3/2016	<ul style="list-style-type: none"> • Approved by MPC. Expanded coverage to other lines of business.
1/7/2016, 1/8/2015	<ul style="list-style-type: none"> • Approved by MPC. No changes.
1/22/2014	<ul style="list-style-type: none"> • Approved by MPC. Review per Kentucky Department of Medicaid regarding admission criteria.
11/7/2013	<ul style="list-style-type: none"> • Approved by MPC. New.