



BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

March 19, 2026

GUIDING PRINCIPLES

Guiding Principles

Purpose of the Guiding Principles is to establish the core foundation principles from which the *Standards and Guidelines* are created and to provide guidance in the absence of a specific standard or guideline.

- 1. The highest priority of these Standards and Guidelines is to maximize community safety through the effective delivery of quality evaluation, treatment and management of juveniles who commit sexual offenses.¹**
- 2. Sexual offenses are traumatic and can have a devastating impact on the victim and victim's family.**

Sexual offenses violate victims and can lead to common and serious consequences across all areas of victims' lives, including chronic and severe mental and physical health symptoms, as well as social, family, economic, and spiritual harm.² Research and clinical experience indicate that victims of sexual abuse often face long-term impact and continue to struggle for recovery over the course of their lifetime.³ The impact of sexual offenses on victims varies based on numerous factors. By defining the offending behavior and holding offenders accountable, victims may potentially experience protection, support and recovery. Professionals working with sexual offenders should be alert to how offenders' behaviors may inflict further harm on persons they have previously victimized.⁴

- 3. Community safety and the rights and interests of victims and their families, as well as potential victims, require paramount attention when developing and implementing assessment, treatment and supervision of juveniles who have committed sexual offenses.⁵**

¹ Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004.

² Mason, F. & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 27(1):27-37; Tjaden, P. & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. *Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice*; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually revictimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry*, 69(9):935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care*. 46(1): 56-64.

³ Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings*, 85(7):618-629.

⁴ Feiring, C., & Taska, L. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child Maltreatment*, 10(4):337-349; Lodrick, Z. (2010). Victim guilt following experience of sexualized trauma: investigation and interview considerations. *The Investigative Interviewer*, 1:54-57; Patterson, D. (2010). The Linkage Between Secondary Victimization by Law Enforcement and Rape Case Outcomes. *Journal of Interpersonal Violence*, 26(2):328-347; Tamarit, J., Villacampa, C., and Filella, G. (2010). Secondary Victimization and Victim Assistance. *European Journal of Crime, Criminal Law and Criminal Justice*, 18(3):281-298.

⁵ Briere & Scott (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage Publications; Morrison (2007). Caring about sexual assault: the effects of sexual assault on families, and the effects on victim/survivors of family responses to sexual assault. *Family Matters*, 76:55-63; O'Doherty, T., McLaughlin, S., Deirdre O'Leary, D. (2001). Recovery work with child victims of sexual abuse: A framework for intervention. *Child Care in Practice*, 7(1):78-88.

When assessing the needs of a juvenile who has committed a sexual offense community safety must be achieved. In the event of a conflict between the two, the MDT shall determine how to meet the needs of the juvenile in a manner that does not compromise or negatively impact community safety.

4. Safety, protection, developmental growth and the psychological wellbeing of victims and potential victims is a priority for the Multidisciplinary Team (MDT).⁶

Victims have the right to safety, to be informed and to provide input to the MDT.

5. Offense-specific treatment must address all types of abusive behaviors and not just the legally-defined delinquent behavior(s) for which they were adjudicated.

6. Treatment and supervision decisions should be informed by a comprehensive evaluation⁷ and ongoing assessments.⁸

It is important to understand that risk assessment measures have limitations and that findings need to be used appropriately (i.e. within the scope of their empirically established limits). The evaluation and ongoing assessment of juveniles who have committed sexual offenses is a process. Ongoing assessment must constantly consider changes in the juvenile, family and community in order to make decisions concerning restrictions, intensity of supervision, placement, treatment and opportunities for positive growth and development of juveniles.

7. Risk assessment of juveniles who have committed sexual offenses should be based on an empirically supported protocol.⁹

The risk assessment protocol, including the selection of instruments, should be tailored to the unique characteristics of the juvenile. A juvenile's level of risk should not be based solely on the sexual offense(s) of adjudication/deferred judgement.

⁶ Gootschall et al. (2015). Value, Challenges, and Solutions in Incorporating Victim Impact Awareness in Offender Rehabilitation - The Results of Qualitative Interviews with Stakeholders. *Victims & Offenders: An International Journal of Evidence-based Research, Policy, and Practice*, 10(3):293-317.

⁷ Chu, M., & Thomas, S. (2010). Adolescent Sexual Offenders: The Relationship Between Typology and Recidivism. *Sexual Abuse: A Journal of Research and Treatment*, 22(2):218-233; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Lleversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirrotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review*, 47 (Part 1), 1-9; Wijk, A. P., Mali, B. R., Bullens, R. A., & Vermeiren, R. R. (2007). Criminal Profiles of Violent Juvenile Sex and Violent Juvenile Non-Sex Offenders: An Explorative Longitudinal Study. *Journal of Interpersonal Violence*, 22(10), 1340-1355.

⁸ Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment*, 23(4):434-455; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders. *What is Next? International Journal of Offender Therapy and Comparative Criminology*, 57(2):208-228; Oneal, B. J., Burns, L. G., Kahn, T. J., Rich, P., & Worling, J. R. (2008). The Treatment Progress Inventory for Adolescents who Sexually Abuse (TPI-ASA). *Sexual Abuse: A Journal of Research and Treatment*, 20(2), 161-187.

⁹ Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ryan, G., Lleversee, T. F., & Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction, (3rd ed.). Wiley; Singh, J. P., Desmarais, S. L., Sellers, B. G., Hylton, T., Tirrotti, M., & Van Dorn, R. A. (2014). From risk assessment to risk management: Matching interventions to adolescent offenders' strengths and vulnerabilities. *Children and Youth Services Review*, 47 (Part 1), 1-9.

8. A multidisciplinary team will be convened, and is responsible for the evaluation, treatment, care and supervision of juveniles who commit sexual offenses.¹⁰

The adoption of these standards and guidelines significantly improves public safety outcomes when all agencies and parties are working cooperatively and collaboratively.

9. Treatment and supervision decisions should be guided by available research and best practice.¹¹

Research with this population continues to emerge, leading to changes of these Guiding Principles and Standards. In the absence of research, decisions should be made cautiously and in accordance with best practices to minimize unintended consequences.

10. Treatment and supervision should be individualized and responsive based on the juvenile's risks and needs.¹²

Juveniles who commit sexual offenses vary in ways such as; age, development, gender, culture, background, strengths, protective factors, pattern(s) of offending and numbers of victims.

11. Evaluation, ongoing assessment, treatment and supervision of juveniles who have committed sexual offenses should be non-discriminatory, humane and bound by the professional code of ethics and law.¹³

Professionals responsible for the evaluation, assessment, treatment and supervision of juveniles who have committed sexual offenses must not discriminate based on race, religion, gender, sexual orientation, disability or socio-economic status. Juveniles who have committed sexual offenses and their families shall be treated with dignity and respect by all members of the multidisciplinary team.

¹⁰ Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; Center for Juvenile Justice Reform (2012). Addressing the Needs of Multi-System Youth - Strengthening the Connection between Child Welfare and Juvenile Justice, Georgetown Public Policy Institute, Washington, D.C.; Lobanov-Rostovsky, C. & Hansen, J. (2013). Evaluation of Policies and Procedures for Juvenile Offenders and Best Practices for the Treatment and Management of Adult Sex Offenders and Juveniles who have Committed Sexual Offenses, Denver, CO: Colorado Department of Public Safety.

¹¹ Bumby, K. M., & Talbot, T. B. (2007). Treating Juveniles who Commit Sex Offenses: Historical Approaches, Contemporary Practices, and Future Directions. In M. C. (Ed.), *Working with Children and Youth who Sexually Abuse: Taking the Field Forward* (pp. 245-261). Lyme Regis, UK: Russell House; Mears, D., & Bacon, S. (2009). Improving criminal justice through better decision making: Lessons from the medical system. *Journal of Criminal Justice*, 37(2):142-154.

¹² Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. *Criminal Justice Review*, 40(3):277-302; Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment*, 23(4):434-455; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology*, 57(2):208-228; Hoge, R. D. (2016). Risk, need, and responsivity in juveniles. In K. Heilbrun (Ed.) *APA Handbook of Psychology and Juvenile Justice* (pp. 179-196). Washington D.C.: APA; Lipsey, M. W. (2009). The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. *Victims and Offenders*, 4(2):124-147; Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. John Wiley & Sons; Ronis, S. & Borduin, C. (2007). Individual, Family, Peer, and Academic Characteristics of Male Juvenile Sexual Offenders, *Journal of Abnormal Child Psychology*, 35(2):153-163; Worling J. R. (2013). Desistence for adolescents who sexually harm (Unpublished document). Retrieved from <http://www.erasor.org/new-protective-factors.html>.

¹³ Birgden, A. & Cucolo, H. (2011). The Treatment of Sex Offenders Evidence, Ethics, and Human Rights. *Sexual Abuse: A Journal of Research and Treatment*, 23(3):295-313.

12. Assessment of the degree of progress in treatment is based on the juvenile's application of relevant changes in their daily functioning.¹⁴

Treatment should include measurable outcomes that will demonstrate progress and successful completion of treatment.

13. Treatment should be holistic and enhance overall health and protective factors.¹⁵

Many juveniles who commit sexual offenses have multiple problems and areas of risk. Research indicates that juveniles are at greater risk for non-sexual re-offenses than for sexual re-offenses.¹⁶ Assessment and treatment must address areas of strengths, risks and deficits to increase the juvenile's abilities to be successful and to decrease the risks of further abusive or criminal behaviors. Treatment plans should specifically address the risks of further sexual offending, other risks that might jeopardize safety and successful pro-social functioning.¹⁷ Treatment plans should also reinforce developmental and environmental assets.

14. Assessment, treatment and supervision should be viewed through an ecological framework of Development.¹⁸

Assessment and intervention with a juvenile who has committed a sexual offense recognizes the nature of adolescent development and the dependence on and influence by social-ecological factors, including family, peer group, community and school. This focus seeks to decrease risk factors and increase protective factors in the juvenile's ecology.

The individualization of evaluations, assessment, treatment and supervision requires particular attention to social and cultural factors. Recognition of these factors are essential when interacting with clients from different social, cultural, and religious backgrounds. A basic premise is to recognize the client's culture, your own culture, and how both affect the client-provider relationship. This premise extends to all professional members of the MDT and positive support persons and is essential in creating an equitable and inclusive environment regardless of differences in culture or lifestyle.

15. Family members/Primary Caregivers should be considered an integral part of evaluation, assessment, treatment and supervision.¹⁹

¹⁴ Hempel, I., Buck, N., Cima, M., Marle, H. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology*, 57(2):208-228.

¹⁵ Leversee, T., & Powell, K. (2012). Beyond Risk Management to a More Holistic Model for Treating Sexually Abusive Youth. In B. K. Schwartz, *The Sex Offender* (Chapter 19). Kingston, NJ: Civic Research Institute.

¹⁶ Caldwell, M. (2010). Study Characteristics and Recidivism Base Rates in Juvenile Sex Offender Recidivism. *International Journal of Offender Therapy and Comparative Criminology*, 54(2):197-209; McCann, K., & Lussier, P. (2008). Antisociality, Sexual Deviance, and Sexual Reoffending in Juvenile Sex Offenders. A Meta-Analytic Investigation. *Youth Violence and Juvenile Justice*, 6(4):363-385; Worling, J. R., & Langstrom, N. (2006). Risk of Sexual Recidivism in Adolescents Who Offend Sexually: Correlates and Assessment. In H. E. Barbaree & W. L. Marshall (Eds.), *The Juvenile Sex Offender* (2nd ed.) (pp. 219-247). New York: Guilford Press.

¹⁷ Perry, G., & Ohm, P. (1999). The role healthy sexuality plays in modifying abusive behaviours of adolescent sex offenders: Practical considerations for professionals. *Canadian Journal of Counseling*, 32(2):157-169.

¹⁸ Borduin et al. (2009). A Randomized Clinical Trial of MST with Juvenile Sexual Offenders: Effects on Youth Social Ecology and Criminal Activity, *Journal of Consulting and Clinical Psychology*, 77(1):26-37; Pullman et al. (2014). Examining the developmental trajectories of adolescent sexual offenders, *Child Abuse & Neglect*, 38(7):1249-1258.

¹⁹ Schroeder, R., Osgood, A., Oghia, M. (2010). Family Transitions and Juvenile Delinquency. *Sociological Inquiry*, 80(4):579-604; Spice, A., Viljoen, J., Latzman, N., Scalora, M., and Ullman, D. (2012). Risk and Protective Factors for Recidivism Among Juveniles

The families'/primary caregivers' abilities to provide informed supervision and support positive changes are critical to reducing risk of re-offense.

Cooperative involvement with family members/primary caregivers enhances juvenile's prognosis in treatment. Family members/primary caregivers possess invaluable information about the juvenile who has committed a sexual offense. Family members can be an important part of the juvenile's support system through the course of treatment and supervision.

Conversely, non-cooperative family members may impede the juvenile's progress.²⁰ It is expected that the MDT will work with the family/primary caregiver to help them support the juvenile through cooperative involvement.

16. Treatment and supervision decisions regarding juveniles who have committed sexual offenses should minimize caregiver disruption and maximize exposure to positive peer and adult role models.

As juveniles move through the continuum of services emphasis should be given to maintaining positive and consistent relationships, including both in and out of a school setting. Research indicates that association with delinquent peers, the absence of pro-social adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.²¹

17. A continuum of care for treatment and supervision options should be available and utilized as needed.²²

Decisions about level of care and supervision are informed by the youth's risk and need, taking into consideration the least restrictive environment while prioritizing community safety. Adjustments in the level of treatment and supervision should be made based on changes in risk and need, and continuity of services across these levels of care should be ensured. Whenever possible, priority should be given to the juveniles residing with their families or within the community in which their family resides.

18. For juveniles who have been removed from the home family reunification can only occur after careful consideration of all the potential risks.²³

Who Have Offended Sexually. *Sexual Abuse: A Journal of Research and Treatment*, 25(4):347-369; Thorton et al. (2008). Intrafamilial adolescent sex offenders: Family functioning and treatment, *Journal of Family Studies*, 14(2-3):362-375; Yoder et al. (2015). The Impact of Family Service Involvement on Treatment Completion and General Recidivism Among Male Youthful Sexual Offenders, *Journal of Offender Rehabilitation*, 54(4):256-277.

²⁰ Baker, A., Tabacoff, R., Tornusciolo, G., Eisenstadt, M. (2003). Family Secrecy: A Comparative Study of Juvenile Sex Offenders and Youth with Conduct Disorders. *Family Process*, 42(1):105-116.

²¹ Burton, D. & Duty, K. & Leibowitz, G. (2011). Differences between sexually victimized and non-sexually victimized male adolescent sexual abusers: Developmental antecedents and behavioral comparisons. *Journal of Child Sexual Abuse*, 20(1):77-93; Miner & Munns (2005). Isolation and Normlessness - Attitudinal Comparisons of Adolescent Sex Offenders, Juvenile Offenders, and Nondelinquents, *International Journal of Offender Therapy and Comparative Criminology*, 49(5):491-504; Righthand, S. & Welch, C. (2004). Characteristics of youth who sexually offend. *Journal of Child Sexual Abuse*, 13(3-4):15-32.

²² Hunter, J. A., Gilbertson, S. A., Vedros, D., & Morton, M. (2004). Strengthening community based programming for juvenile sex offenders: Key concepts and paradigm shifts. *Child Maltreatment*, 9(2):177-189; Silovsky, J. F., Swisher, L. M., Widdifield Jr., J., & Burris, L. (2011). Clinical considerations when children have problematic sexual behavior. In P. Goodyear-Brown (Ed.). *Handbook of child sexual abuse: Identification, assessment, and treatment*. New Jersey: John Wiley & Sons.

²³ Hackett et al. (2014). Family Responses to Young People Who have Sexually Abused: Anger, Ambivalence and Acceptance, *Children & Society*, 28(2):128-139; Silovsky et al. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review*, 33(8):1435-1444; Swisher, L., Silovsky, J., Stuart, R., &

The ability of parents to provide informed supervision in the home must be assessed in relation to the particular risks of the juvenile. Reunification of the juvenile with the family should occur only after the parents/primary caregivers can demonstrate the ability to provide protection and support of the victim(s) and other children in the home, as well as address the needs and risks of the juvenile.

19. Juveniles shall not be labeled as if their sexual offending behavior defines them.²⁴

It is imperative in understanding, treating and intervening with juveniles who commit sexual offenses to consider their sexual behavior in the context of the many formative aspects of their personal development. As juveniles grow and develop their behavior patterns and self-image constantly change. Research suggests that most juveniles will not go on to offend sexually as adults.²⁵ Not all juveniles who have engaged in sexually abusive behavior require extensive or intensive interventions in order to reduce their risk for reoffending because identity formation is a significant developmental task during adolescence, labeling juveniles based solely on sexual offending behavior may cause potential damage to long-term pro-social development.

20. Successful completion of treatment and supervision depends upon a juvenile's willingness and ability to cooperate. Accordingly, members of the MDT should employ practices designed to maximize the juvenile's participation and accountability.²⁶

Pierce, K. (2008). Children with Sexual Behavior Problems. *Juvenile and Family Court Journal*, 59(4):49-69; Harper, B. (2012). *Moving Families to Future Health: Reunification Experiences After Sibling Incest*. Doctorate in Social Work (DSW), Dissertations. Paper 26; Price, D. (2004). *Rebuilding Shattered Families: Disclosure, Clarification and Reunification of Sexual Abusers, Victims, and Their Families*, *Sexual Addiction & Compulsivity*, 11(4):187-221.

²⁴ Miner et al. (2006). Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders, *Sexual Offender Treatment*, 1(3); Schultz, C. (2014). The Stigmatization of Individuals Convicted of Sex Offenses: Labeling Theory and The Sex Offense Registry. *Themis: Research Journal of Justice Studies and Forensic Science*, 2(4):64-81.

²⁵ Carpentier, J., & Proulx, J. (2011). Correlates of Recidivism Among Adolescents Who Have Sexually Offended. *Sexual Abuse: A Journal of Research and Treatment*, 23(4):434-455; Fanniff, A., & Becker, J. (2006). Developmental considerations in working with juvenile sexual offenders. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 119-141). Holyoke, MA: NEARI Press; Hempel et al. (2013). Review of Risk Assessment Instruments for Juvenile Sex Offenders

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²⁶ Brogan, L., Haney-Caron, E., NeMoyer, A. & DeMatteo, D. (2015). Applying the risk-needs-responsivity (RNR) model to juvenile justice. *Criminal Justice Review*, 40(3):277-302; Englebrecht et al. (2008). "It's not my fault": Acceptance of responsibility as a component of engagement in juvenile residential treatment, *Children and Youth Services Review*, 30(4):466-484; Reicher (2013). Denying Denial in Children with Sexual Behavior Problems, *Journal of Child Sexual Abuse*, 22(1):32-51.