NOTICE OF PUBLIC MEETING
ARIZONA SEX OFFENDER MANAGEMENT BOARD
JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

Pursuant to Arizona Revised Statutes (A.R.S.) § 38-431.02, notice is hereby given to the members of the **Arizona Sex Offender Management Board Juvenile Guidelines and Standards Subcommittee** (the "Subcommittee") and to the general public that the Subcommittee will hold a meeting, open to the public, on **April 16, 2026**.

The **April 16, 2026,** Subcommittee meeting will be a hybrid access meeting. This means that the public has the opportunity to participate in person or virtually. Information on how the public may attend is outlined below.

Please note the location of the **April 16, 2026,** Subcommittee meeting:

Arizona State Capitol
1700 West Washington Street (First Floor Conference Room)
Phoenix, Arizona
Virtual Meeting Access: Microsft Teams Meeting : Join
https://teams.microsoft.com/meet/24344609905544?p=aJzjgvjXbtAUDln98g
Meeting ID: 243 446 099 055 44
Passcode: Zr6k6kh3
Dial in by phone**:**+1 480-536-7328,,53424801#
Phone conference ID: 534 248 01#

The boardroom will be open to members of the public at 1:15 p.m.

A copy of the meeting agenda is attached. The Subcommittee reserves the right to change the order of items on the agenda.

Pursuant to A.R.S. § 38-431.02(H), the Subcommittee may discuss and take action concerning any matter listed on the agenda.

Pursuant to A.R.S. § 38-431.03(A)(2), the Subcommittee may vote to convene in executive session, which will not be open to the public, for discussion or consideration of records exempt by law from public inspection.

Pursuant to A.R.S. § 38-431.03(A)(3), the Subcommittee may vote to convene in executive session, which will not be open to the public, for legal consultation and advice concerning any item on the agenda.

Persons with a disability may request reasonable accommodation, such as a sign language interpreter, by contacting Ms. Ashlesha Naik at 602-223-2611 or via email at AZSOMB@AZDPS.GOV. Requests should be made as early as possible to allow time to arrange the accommodation(s).

DATED AND POSTED this 14th Day of April 2026.

By Jenna G. Mitchell
Major Jenna G. Mitchell
AZSOMB Program Manager

ARIZONA SEX OFFENDER MANAGEMENT BOARD
JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE
THURSDAY, April 16, 2026
Regular Session

1:30 PM

ALL ITEMS ON THIS AGENDA ARE OPEN FOR DISCUSSION AND POSSIBLE ACTION, INCLUDING REPORTS AND ACTION ITEMS.

THE AGENDA AND BACKGROUND MATERIAL ARE PROVIDED TO BOARD MEMBERS ELECTRONICALLY (WITH THE EXCEPTION OF MATERIAL RELATING TO POSSIBLE EXECUTIVE SESSIONS) AND POSTED ON THE ARIZONA PUBLIC MEETING WEBSITE AT https://publicmeetings.az.gov/. ADDITIONALLY, A HARD COPY OF THE AGENDA IS AVAILABLE AT 2222 WEST ENCANTO BLVD., PHOENIX, AZ. PLEASE EMAIL AZSOMB@AZDPS.GOV TO INSPECT THE DOCUMENTS.

REMINDER: As required by Open Meeting Law, please refrain from engaging in conversations, texts, emails and other forms of communication with individual board members. All questions, comments, deliberations and decisions should be stated to the public body as a whole in open session.

1. **ROLL CALL**

2. **MATTERS FOR DISCUSSION AND POSSIBLE ACTION**

   a. Introduction of New Subcommittee Member – The Honorable Anna Young

   b. Arizona Department of Child Safety (DCS) Presentation –
   Ms. Marisol Manjarrez, Program Supervisor, DCS Placement Administration &
   Mr. Daniel Bugarin, DCS Statewide Placement Specialist

   c. Old Business: Discussion of Guiding Principles

   d. Discussion Regarding Documentation from Juvenile Court –
   Practices for Juveniles with Sexually Abusive Behaviors (JSAB)

3. **THE SUBCOMMITTEE MAY VOTE TO CONVENE AND ENTER INTO AN EXECUTIVE SESSION FOR ANY REASON AUTHORIZED BY A.R.S. § 38-431.03** including personnel matters, confidential records, legal advice, litigation, contract negotiations, employee salary discussions, and international or tribal negotiations. (To do so, the public body must first vote publicly to enter executive session, specifying the reason, and no legal action or final decisions can be made during the session. All motions and voting must be conducted after return to the public session.)

4. **ADJOURNMENT**

NEXT MEETING: May 14, 2026, 1:30 p.m. -3:30 p.m.

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

DOCUMENTATION ON JUVENILE COURT PRACTICES FOR JUVENILES WITH SEXUALLY ABUSIVE BEHAVIORS

BY MR. JOSEPH KELROY, DIRECTOR

JUVENILE JUSTICE SERVICES DIVISION,

ARIZONA SUPREME COURT

8-350.01. Youth sex offenders; treatment; definition

A. If the court or the adult or juvenile probation department places a sex offender in a sex offender treatment program, the treatment provider or, if the treatment is provided by the state department of corrections or the department of juvenile corrections, the state department of corrections or the department of juvenile corrections shall place the offender in a treatment program with similar offenders of a similar age and developmental maturity level, if group treatment is prescribed by the treatment provider.

B. A mental health treatment program that a sex offender is required to participate in by a court, an adult or juvenile probation department, the state department of corrections or the department of juvenile corrections:

1. Shall comply with the professional code of ethics from the association for the treatment of sexual abusers.

2. Shall not include the use of images that are in violation of title 13, chapters 35 and 35.1.

C. For the purposes of this section, "sex offender" means a person who is twenty-one years of age or younger who is adjudicated delinquent for or convicted of an offense that involves a violation of title 13, chapter 14 or 35.1 and that does not involve the discharge, use or threatening exhibition of a deadly weapon or dangerous instrument.

Association for the Treatment of Sexual Abusers

ATSA

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ATSA

Practice Guidelines

for Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior

2017

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Association for the Treatment of Sexual Abusers

PRACTICE GUIDELINES FOR ASSESSMENT, TREATMENT, AND INTERVENTION WITH ADOLESCENTS WHO HAVE ENGAGED IN SEXUALLY ABUSIVE BEHAVIOR

2017

(Short Title: ATSA Adolescent Practice Guidelines)

INTRODUCTION

Dear Colleagues,

The ATSA Adolescent Guidelines Committee is pleased to present the ATSA Practice Guidelines for Assessment, Treatment, and Intervention of Adolescents Who Have Engaged in Sexually Abusive Behavior (2017).

It was an honor to be tasked with developing ATSA's first guidelines specific to adolescents. It was a long, laborious process and we appreciate everyone's patience in waiting for the final product. We hope that you will be as excited about the final guidelines as the committee is.

While these guidelines were developed by ATSA, the intent is to support and guide the work of both ATSA members and non-members. You will notice that we use "practitioner" rather than "member" in the body of the guidelines. This was a deliberate decision by the committee to reflect that the guidelines were developed to provide support to all professionals involved with this group of youth.

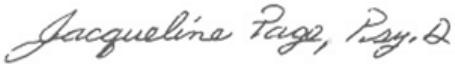
We thank the membership for their support throughout this process including taking the time to provide comments and feedback on the official draft during the membership review. We also thank the ATSA Executive Board of Directors for their careful review, response, and approval of the final document.

In addition we are grateful for the assistance and guidance of Maia Christopher, ATSA Executive Director, who never wavered in her support and belief in the project. And, we thank ATSA staff members Aniss Benelmouffok, Sarah Gorter, Kelly McGrath, and Ann Snyder, and the many behind-the-scenes people who were tasked with reviewing, formatting, and preparing the document for publication.

This document is for you, and it is our hope that you find the ATSA Adolescent Practice Guidelines beneficial.

Sincerely,

The ATSA Adolescent Practice Guidelines Committee:



Jacqueline Page, Psy.D., Co-Chair

Tom Leversee, LCSW, Co-Chair

Kevin Creeden M.A.

Elizabeth J. Letourneau, Ph.D.

Sue Righthand, Ph.D.

Daniel Rothman, Ph.D.

Maia Christopher,
Executive Director and Ex-Officio Committee Member

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A. GENERAL EXPECTATIONS

The Association for the Treatment of Sexual Abusers (ATSA) is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning, ATSA promotes evidence-based practice, sound public policy, and collaborative community strategies that support effective assessment, treatment, and management of individuals who have sexually abused or are at risk to abuse.

The goals and objectives of ATSA include, but are not limited to:

- Disseminating extant and emerging research about effective clinical and other treatments of individuals who engage in sexually abusive behavior;
- Promoting empirically informed assessment, clinical treatment, and other interventions for individuals who have sexually abused or are at risk to sexually abuse;
- Reducing the risk of individuals to engage in sexually abusive or other harmful behaviors and increasing their ability to live healthy, productive lives with the ultimate goal of making communities safer;
- Preventing sexual abuse through a collaborative, multi-disciplinary, public health approach which guides policy and clinical practice; and
- Maintaining high standards of integrity and professionalism within the ATSA membership.

In support of these goals, the Practice Guidelines for the Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior 2017 (ATSA Adolescent Practice Guidelines) provide guidance to practitioners and others who work with adolescents who have sexually abused or are at risk to abuse. ATSA members agree to abide by these guidelines and integrate them into all practice and programmatic decision making.

B. INTENDED SCOPE, APPLICABILITY, AND USE

The ATSA Adolescent Practice Guidelines apply to practitioners who manage and treat adolescents (youth ages 13 through 17) who have engaged in sexually abusive behavior or may be at risk to engage in sexually abusive behavior. This includes adolescents involved in the child welfare and/or juvenile justice systems.

These guidelines define "practitioners" as individuals who may work in a range of disciplines and professions including, but not limited to, treatment providers, case managers, juvenile court personnel, law enforcement officers, probation officers, investigative personnel, evaluators, policy and law makers, and other professionals involved in working with adolescents who have engaged in sexually abusive behavior. Although these guidelines focus on adolescents ages 13 through 17, youth vary in their cognitive and psychological development. Therefore, ATSA considers this age range to be advisory and recognizes there are times when these guidelines may be reasonably applicable and helpful in working with youth outside of the specified age range.

The positions articulated in these guidelines are intended to serve as recommended, current best practices for practitioners providing services to adolescents who have engaged in sexually abusive behavior. These guidelines are not intended to replace any local, state, provincial, or federal statutes, provisions, mandates, promulgated ethical codes, or practice requirements/parameters established for regulated professions. Practitioners are encouraged to take steps to achieve an appropriate resolution in cases where a conflict between these guidelines and legal and professional obligations occur.

ATSA further recommends that practitioners actively educate others including those involved in treatment, mental health, child welfare, juvenile justice, government, and policy making about these guidelines. Doing so will help promote current evidence-based and ethically sound practices; offer a measure of protection for adolescents, practitioners, and the public against unethical, non-informed, or unprofessional practices with this population; and serve as a catalyst for additional empirical research to further inform practices and policies regarding adolescents who have engaged in sexually abusive behavior.

For information on children with sexual behavior problems who are 12 years and younger, please refer to the Report of the ATSA Task Force on Children with Sexual Behavior Problems (2006). For information on adult males who have sexually offended, refer to ATSA Practice Guidelines for Assessment, Treatment, and Management of Male Adult Sexual Abusers (2014). In addition, for information specific to individuals with intellectual disabilities and problematic sexual behavior, please refer to Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors (2014), or the Assessment and Treatment of Adolescents with Intellectual Disabilities Who Exhibit Sexual Problems or Offending Behaviors (2015). These and other resources are available on the ATSA website at www.atsa.com.

The descriptor "adolescents who have engaged in sexually abusive behavior" has been purposefully adopted by ATSA to describe the population covered by these guidelines.

Although terms such as "juvenile sex offender" and "adolescent sex offender" are commonly used, these kinds of descriptors, which characterize a young person based on his/her behavior, imply that the behavior is long lasting, intractable, or permanent. These notions are contraindicated by current research, which finds that problematic sexual behaviors in the vast majority of youth are transitory. In addition, the term "sex offender" fails to make a distinction among the continuum of behaviors broadly described in legal and popular contexts, which can range from voyeurism to violent sexual assault.

Although the term "juvenile sex offender" implies a legal status in some juvenile justice systems, these kinds of labels have the potential to negatively shape a young person's identity and self-concept during an important developmental period through which he/she might otherwise successfully navigate. Such labels are misleading, unhelpful, and at times harmful to the youth, his/her family, and/or the treatment process. ATSA selected the term "abusive" to refer to sexual conduct that is interpersonally harmful to distinguish it from other sexual behaviors that may be potentially problematic but do not harm another person. Finally, the term "adolescents who have engaged in sexually abusive behavior" describes rather than labels, and denotes that this is a past behavior rather than a current or future one, which helps the adolescent, practitioner, and public expect correction of the youth's harmful behavior.

The ATSA Adolescent Practice Guidelines are grounded in scientific evidence, sound general practice principles, and accepted ethical standards in an array of relevant areas including, but not limited to, child and adolescent development, neuroscience, sociology, criminology, and clinical and forensic psychology. As research and scientific knowledge evolve over time, it is important that practitioners stay current on relevant studies in the variety of fields that cover these youth and influence their treatment. To assist with this, ATSA will periodically review and revise these guidelines as appropriate.

C. SEXUAL ABUSE AS A PUBLIC HEALTH ISSUE

Prevalence and Recidivism Rates

Sexually abusive behavior by adolescent youth is a serious public health, public safety, and public policy problem. The most recent available estimates of abusive sexual behavior find that adolescents commit more than one-third of all sexual offenses against minors. However, the percent of adolescents committing these offenses is low – approximately 4 to 5 percent of teenaged males and slightly more than 1 percent of teenaged females have perpetrated acts of sexual abuse.

Current data also show that the base rate for sexual recidivism is low – between 3 and 10 percent, with a global average of approximately 5 percent. Studies from the past 15 years have found the reported mean sexual recidivism rate to be approximately 2.75 percent. Research shows that sexually abusive behavior in adolescents rarely persists into adulthood. The vast majority of most adolescents who have engaged in sexually abusive behavior do not continue to sexually abuse and are not on a life trajectory for repeat offending.

Youth who do reoffend are far more likely to do so with nonsexual offenses than with sexual ones. There have been some studies that report higher rates of sexual reoffending and there is a small subset of adolescents with considerable and/or persistent risk for perpetrating sexual harm who require special consideration. However, these youth are the exception rather than the norm.

Sexual abuse can cause grave harm, may have long-lasting impacts on the people victimized and their families and communities, and may require legal interventions and specialized treatment. Effective clinical practice and public policy, informed by sound research and an understanding of these youth, are essential to successfully address and prevent sexual abuse. And, as with any public health issue, resolution requires a collaborative approach among many individuals including practitioners, legal professionals, juvenile justice professionals, the public, its representatives, and others. As an organization dedicated to preventing sexual abuse, ATSA supports a shared effort to increase community safety, reduce recidivism and prevent future victimization, and effectively rehabilitate these youth.

Assessment and Intervention

From a neurodevelopmental perspective, adolescence is a very dynamic and fluid stage of development that extends well past the conventional or legal age of adulthood, often into the early to mid-20s. In many ways the brain of a typical mid- to late-adolescent (especially the parts of the brain most responsible for stimulation-seeking, judgment, and decision-making abilities) more closely resembles the brain of a younger teenager than that of a mature adult. Some characteristics associated with adolescent behavior, therefore – such as poor impulse control, susceptibility to peer influence, emotionality, recklessness, lack of responsibility, and a limited ability to anticipate and appreciate future consequences – have been linked to identifiable structural and functional features of adolescent brains. Consequently, compared to adults, adolescents are more highly influenced by peers and social rewards, less future-oriented, less opposed to risk, and less able to manage their impulses, emotions, and behavior. Factors that strongly impact the adolescent brain and can exacerbate or prolong the behavior issues associated with adolescence include, but are not limited to, childhood neglect, trauma, and abuse; cognitive factors including intelligence, executive functioning, and learning style; and developmental problems such as autism spectrum disorders.

The differences between adults and adolescents, and the rapid changes that take place during adolescence, are key to a range of adolescent behavior problems – including sexually inappropriate or sexually abusive behaviors – and to the types of interventions that work most effectively with youth. Because adolescents are known to depend on and be strongly influenced by a number of social, environmental, and ecological factors and systems such as family, peers, and school, it follows that effective interventions need to focus on and involve the key adults and systems in the young person's life. This may include involving caregivers, family, and personnel within the child welfare, educational, recreational, mental health, and juvenile or criminal justice systems, rather than solely focusing on factors that lie within the individual adolescent.

Effective treatment also entails holding adolescents responsible for their behavior at an appropriate developmental level. A youth's maturity and capacity for taking responsibility for his/her actions is greatly affected by his/her social environment and stage of cognitive development, as well as any insult or injury such as neglect and trauma that might impact that cognitive development. Helping a youth mature and develop learn to be accountable for his/her actions requires involvement by the youth's caregivers and other significant adults in the adolescent's life, upon whom the youth relies for influence in developing the capacity to grow and change.

Properly targeted and implemented interventions significantly reduce risk and recidivism. These interventions often can be delivered in the community as opposed to residential facilities or correctional programs, although at times the youth's risk and needs may necessitate residential or correctional placement for their well-being and community safety. Interventions often address social/environmental risk factors (e.g., reducing parent-teen conflict, enhancing parental monitoring, enhancing the youth's peer relationship skills, and supporting his/her involvement and success in academics and prosocial recreation). While this may be more challenging for youth in out-of-home placements, it remains a relevant focus of treatment.

The fact that these treatment methods are highly similar to effective interventions for youth with general (nonsexual) conduct problems challenges the notion that most youth who engage in abusive sexual behavior require residential treatment or specialized sex-offense-specific treatment focusing predominantly or only on the sexually abusive behavior. The most effective interventions for sexually abusive behavior in adolescents are those that address the underlying risk factors relevant to both sexual recidivism and nonsexual conduct problems. As noted, there are cases in which residential or secure out-of-community placements and/or a concentrated focus on specialized treatment methods may be necessary to address particularly salient risk factors such as persistent sexually abusive behavior or sexual interests involving force, coercion, or children; significant behavioral health issues; chronic mental health issues; and when the youth's resulting risk/needs necessitate more intensive management. However, most youth can safely remain in the community during treatment.

Many adolescents who have engaged in sexually abusive behavior do not require extensive or intensive interventions to reduce their risk for reoffending. In fact, for some youth who are generally rule-compliant and prosocial, there are natural, logical, and easily implemented processes that will address the adolescent's risk and needs. These may include such things as natural consequences (e.g., being in trouble with the family, involvement with child welfare and/or law enforcement), maturation, healthy relationship development, healthy sexuality education (including understanding abuse and consent), and parental involvement and monitoring. In these cases, the potential for harm caused by high-intensity interventions, which may involve such things as exposure to an antisocial peer group or isolation from one's family and supports, could be detrimental and inadvertently impair an adolescent's psychosocial functioning and increase the risk for future abusive sexual conduct or other delinquent behaviors. Careful, individualized assessments will determine risk factors, protective factors, and developmental needs, and provide appropriately matched intervention plans.

There are some notable differences between adolescents who commit sexual offenses and those who commit nonsexual crimes that may require specific types of interventions. For example:

- Adolescents who have committed sexual offenses appear more likely to have been sexually victimized and/or exposed to sexual content or pornography at an earlier age than adolescents with nonsexual offenses.
- Youth who have engaged in sexually abusive behavior may be more likely than youth who have committed nonsexual offenses to report higher levels of social isolation, anxiety, and low self-esteem.
- Adolescents who have engaged in sexually abusive behavior may be less likely to have significant criminal histories, associate with antisocial peers, or have substance abuse problems than youth who have committed nonsexual crimes.
- Youth who have offended sexually may be more likely to have sexual interests oriented toward younger children and/or violence than youth who have offended nonsexually.

These findings may help practitioners narrow the focus of intervention efforts, where appropriate, and base interventions on the individual youth's risk, needs, and strengths. Recent research consistently indicates that adolescents who engage in sexually abusive behavior are diverse. These youth differ from one another in numerous ways, including the motivation for their behavior, age and maturity level, family background, learning styles and challenges, and risk factors for reoffending. Further complicating matters is that the factors which led to the development of a behavior in the first place may not be the same factors that maintain that behavior over time.

In summary, adolescent sexually abusive behavior is influenced by a variety of risk and protective factors occurring at the individual youth, family, peer, school, neighborhood, and community levels. Practitioners' assessment, intervention, and management efforts must recognize the array of influencing factors. There is certainly no one-size-fits-all explanation for abusive sexual behaviors, no more than there is a single method for addressing them.

Public Policy

Public health and public safety are both jeopardized by ineffective or misguided public policy and criminal justice efforts. This is especially true for adolescents in jurisdictions where policies designed for adults have been applied to juveniles. For many decades in North America, interventions and treatment approaches were typically simply borrowed from the adult field due to the lack of literature or research about adolescents and brain development. The assumption was that all adolescents who engaged in sexually abusive behaviors were mini-adults. Adolescents were viewed as being high risk and requiring intensive, long-term, specialized treatment.

During the past decade, however, research has challenged those beliefs and provided a new perspective. As a result, practice has shifted to reflect an empirically grounded, caregiver-involved, developmentally appropriate approach for addressing abusive sexual behavior by adolescents. However, public policy has not yet caught up with this knowledge. For example, in the United States, research findings have repeatedly demonstrated that sex offender management policies such as registration and public notification – especially when applied to youth – are ineffective at reducing already low sexual recidivism rates.

Moreover, such policies have collateral effects that frequently produce more harm than good. For example, such laws may have harmful effects on prosocial development by disrupting positive peer relationships and activities; interfering with school and work opportunities; and resulting in harassment, rejection, social alienation, and lifelong stigmatization and instability. Such practices are inconsistent with community safety and promotion of prosocial development and, in fact, may actually elevate a youth's risk by increasing known risk factors for sexual and non-sexual offending. Policies that obstruct healthy adolescent development generally are poor practice and financially costly.

In contrast, research findings indicate that rehabilitative efforts with most youth are effective and that therapeutic interventions, rather than social control strategies, are not only more promising and more successful, but also more cost-effective. And in general, what is good for public health and public safety often is the very same set of conditions that promote healthy adolescent development. Effective public policy and practice for adolescents who have engaged in sexually abusive behavior involves a strong rehabilitative focus. At times, criminal justice sanctions may be warranted, but they are not effective when applied in isolation without consideration of those interventions needed to facilitate broader prosocial development and reformation. Support of a rehabilitative approach is consistent with the more general juvenile justice philosophies in most countries and recognizes adolescence as a time of hope and opportunity for positive outcomes.

D. FOUNDATIONAL POINTS OF THE ATSA ADOLESCENT PRACTICE GUIDELINES

Empirical Framework

The ATSA Adolescent Practice Guidelines use an evidence-based framework that supports effective treatment and management of adolescents who have engaged in sexually abusive behavior. The Risk-Need-Responsivity Principles (RNR) provide the empirical framework for these guidelines.

Risk: The Risk principle focuses on factors within the adolescent and his/her environment associated with sexual and/or general reoffending. Consistent with this principle, the number and constellation of a youth's risk factors, as established and identified through appropriate assessment, determine a youth's need for structure and supervision as well as the intensity of treatment services. Adolescents with the highest risk are provided the most intensive services in more restrictive settings.

Need: The Need principle focuses on dynamic risk factors that, if modified, would reduce the adolescent's risk for sexual or general reoffending. This principle ensures the target and focus of interventions are directly related to the dynamic risk factors for reoffending that have been assessed as present for the individual youth. Other factors that are present, but not necessarily empirically related to recidivism, also may be addressed to support the well-being of the youth.

Responsivity: The Responsivity principle incorporates effective methods to maximize the adolescent's and his/her family's ability to benefit and learn from rehabilitative interventions. This principle states that interventions are to be delivered in ways that are sensitive and responsive to the youth's learning style, cognitive or developmental strengths and challenges, mental health status, psychological characteristics, and motivation to change, as well as his/her relevant cultural, gender, and other individual and family factors that affect the youth's and his/her family's ability to positively engage in and respond to interventions. This principle also notes the need to adapt and adjust the treatment and interventions as the adolescent matures and changes, or as more information is acquired that would suggest appropriate modifications.

Foundational Points

1.0 **Adolescents who have engaged in sexually abusive behavior are fundamentally different from adults who have sexually offended, and require a different set of guidelines with respect to assessment, intervention, and public policy approaches. Sanctions and treatment approaches developed for adults should not be applied to adolescents except in rare cases (e.g., when developmentally appropriate and research supports their use).**

1.1 Adolescents who have engaged in abusive sexual behavior are a diverse group of individuals. As such, each individual has differing strengths, risks, needs, and responsivity factors, as well as protective factors.

1.2 Decisions about extensiveness and intensity of interventions are informed by an applicable assessment. Adolescents who engage in these abusive behaviors are very unlikely to continue them into adulthood. Not all adolescents who have engaged in sexually abusive behavior require extensive or intensive interventions to reduce their risk for reoffending.

1.3 Interventions for adolescents who have engaged in sexually abusive behavior and who have other indicators of risk associated with delinquency should include interventions for general delinquent conduct. Those youth who do reoffend are much more likely to commit a nonsexual offense than a sexual one.

1.4 Assessments of adolescents who engage in sexually abusive behavior are multidimensional, combining multiple sources of information including interviews and observations, record reviews, self-reports, and parent-reports using the best evidence-based strategies, evaluations, and risk assessment instruments available.

1.5 Practitioners understand that sex-offending-specific risk assessment measures have limitations; that findings need to be used appropriately (i.e., within the scope of their empirically established limits); and that the risk assessments need to be conducted at repeated intervals taking into account the adolescent's progress and changing social, family, developmental, and environmental contexts.

1.6 Effective interventions are evidence-based, holistic, and individualized according to each youth's risk, needs, developmental level, family support, and protective and responsivity factors.

1.7 Treatments that incorporate a caregiver/family-involved model that promotes community safety, and healthy and prosocial adolescent development, are effective in reducing recidivism, especially for higher-risk youth.

1.8 Intervention duration should be guided by the risk-relevant needs of the youth and his/her family. Decisions about management and supervision are informed by the youth's protective factors, risk factors, and community safety.

1.9 Most adolescents who have engaged in abusive sexual behavior can be maintained safely in the community. Out-of-home, residential, or correctional placements, although at times necessary, are made based on the individual youth's risks and needs.

1.10 To minimize negative effects associated with out-of-home and residential settings – such as possible negative peer association and influences – and to maximize opportunities for prosocial activities and positive family or other supports, individualized interventions should be offered in the least restrictive settings possible based on the youth's risk, needs, and community safety.

1.11 Effective policies and criminal or juvenile justice initiatives need to be guided by current, empirical evidence that involves a strong rehabilitative focus and fosters healthy adolescent development while facilitating community safety.

1.12 Therapeutic interventions for adolescents, rather than social control strategies, generally are more successful and more cost-effective.

E. ASSESSMENTS OF ADOLESCENTS WHO HAVE SEXUALLY ABUSED

Overarching Assessment Guidelines

Sound assessments guide effective interventions and inform an array of decisions about an adolescent's care and treatment. Examples include:

- child welfare involvement and interventions;
- juvenile justice and other legal decisions (e.g., diversion from the juvenile justice system, disposition, registration, and notification);
- transitions from out-of-community placements (e.g., residential and correctional programs);
- family reunification and reintegration; and
- community supervision and case planning.

Quality assessments identify and provide information about an individual adolescent's risk, needs, and responsivity factors. Given that the research clearly notes adolescents who have engaged in sexually abusive behavior are more likely to recidivate nonsexually than sexually, areas related to general delinquency risk and needs warrant consideration in the assessment. Assessments determine risk-relevant intervention strategies and provide information about factors impacting responses to treatment. Assessments also inform decisions about youth who may need a more restrictive environment or more intensive services as well as youth who may need little or no further intervention and for whom common sex-offense-specific interventions, high levels of restrictions, or punitive sanctions may unintentionally do harm.

Assessments of adolescents who have engaged in sexually abusive behavior encompass multiple domains and are most reliable when practitioners incorporate a range of sources of information in addition to the adolescent and caregiver. Other sources of information may include educational and treatment records as well as information from other professionals involved in the case such as probation officers, case managers, legal representatives, law enforcement officers, courts, and state agencies. It also is important to note that risk, needs, and circumstances change over time, and that the impact of adolescent development may therefore require ongoing periodic assessments of the adolescent to ensure changes, progress, and other developmental factors are taken into consideration.

Conducting Assessments

2.0 **Practitioners conduct developmentally sensitive, ethical, and responsible assessments that support well-informed decision making and maintain the profession's credibility and integrity.**

2.1 Practitioners conduct assessments in accordance with established ethical guidelines and standards as well as appropriate jurisdictional laws and policies. Practices should be consistent with practitioners' professional ethical codes and applicable forensic assessment guidelines, working within the boundaries of their disciplines/license and the ATSA Code of Ethics 2017. If laws are inconsistent with ATSA's ethical standards, practitioners will work to resolve the disparity, decline to conduct the assessment, or comply with the law.

2.2 Practitioners conduct assessments in accordance with professional guidelines and standards developed for adolescents in general as well as adolescents who have sexually abused.

2.3 Practitioners are knowledgeable about normative adolescent development and recognize that maturational processes vary between, as well as within, individual youth. Thus, practitioners conduct developmentally sensitive assessments recognizing that adolescence is a time of rapid change and growth.

2.4 Practitioners are knowledgeable about the range of sexual behavior in adolescents, remain current with research, and review current normative information so they can competently assess the serious nature of an adolescent's behavior.

2.5 Practitioners possess the required training, knowledge, and expertise necessary to conduct assessments of adolescents who have engaged in sexually abusive behavior. Practitioners understand that this field is dynamic and remain current with changes and advancements in their profession through collaboration and training.

2.6 Practitioners understand that evaluator skill deficits or limitations may negatively impact the assessment process and findings. Practitioners conduct objective and impartial assessments, and refer or recommend the adolescent be referred to another evaluator or agency if they believe the assessment process and findings could be compromised in any way.

2.7 Practitioners disclose to supervisors and/or referral sources any skill deficits or limitations they may have that would interfere with their ability to adequately assess the adolescent. If the assessment process and findings might be compromised, practitioners make appropriate accommodations, refer the adolescent to another evaluator/agency, or conduct the assessment with adequate consultation from a qualified professional. The ultimate objective is that the practitioner provides a reliable and beneficial assessment.

2.8 Practitioners are responsible for ensuring that an evaluation related to an adolescent's sexually abusive behavior is conducted only for appropriate cases when there is definitive information that the adolescent engaged in sexually abusive behavior. This includes, but is not limited to, the following:

- The agency responsible for investigating allegations of sexually abusive behavior and determining whether the behavior occurred has substantiated that the behavior occurred.
- The behavior has been substantiated by the appropriate jurisdictional investigative agency.
- The adolescent has been adjudicated in court on a sex-abuse-related offense.
- The sexually abusive behavior was directly observed by a reliable, responsible source.
- The youth admits to having engaged in sexually abusive behavior.

2.9 Practitioners consider community safety and the prevention of additional sexual abuse as core principles of the assessment process.

2.10 Practitioners take into account the adolescent's current legal status and the ways in which that status may influence the nature, scope, or validity of the assessment. Practitioners recognize that assessments cannot prove or disprove that sexual abuse has occurred, that this is not the role of an assessment, and that an assessment cannot predict with certainty whether such behavior will or will not recur. Practitioners should educate referral sources accordingly.

2.11 Practitioners recognize that adolescents who sexually abuse are a heterogeneous mix and there is no profile for adolescents who have engaged in sexually abusive behavior. Thus, statements that an adolescent fits or does not fit a profile are inappropriate.

2.12 Practitioners recognize that most research studies have not focused on subpopulations of adolescents who have engaged in sexually abusive behavior such as adolescent females, adolescents with cognitive or developmental challenges, and adolescents from varied cultural backgrounds. Due to these limitations in the research, including research specific to risk assessment tools, practitioners ensure they review the relevant research available to inform the assessment content and process for these subgroups of youth.

2.13 Practitioners recognize that adolescent development and circumstances are in flux, and conduct reassessments at regular intervals – at least semi-annually – to monitor progress, guide treatment planning, and inform administrative or legal decisions.

2.14 Throughout the assessment process, practitioners educate referral sources and potential consumers of the assessment about the appropriate purposes, potential misuses, benefits, and limitations involved when assessing adolescents who have sexually abused.

Purpose of Assessment

3.0 **Practitioners clarify and document the purpose of an assessment and ensure that empirically based assessment strategies can answer the referral questions. Practitioners then conduct assessments that are responsive to those concerns and the needs of the adolescent, family, caregiver, and safety of the community.**

3.1 Practitioners take reasonable steps to afford the adolescent and his/her legal guardian the opportunity to make an informed decision about participating in the assessment process and to decline participation if they so choose. These steps include, but are not limited to:

- explaining the nature and purpose of the assessment;
- outlining potential benefits, risks, and limitations of the assessment procedures that will be used;

- explaining the potential implications of participating or declining to participate in the assessment; and
- explaining the limits of confidentiality, such as persons or entities to whom the findings will be provided and under what circumstances information will be released to law enforcement if additional individuals are identified as victims of abuse.

3.2 Practitioners will review the referral question(s), develop an appropriate assessment protocol, and recognize that assessments have potentially substantial or severe life-altering consequences (e.g., residential placement, incarceration, registration and notification, and civil commitment).

Forensic-Related Assessments

Not all adolescents who have engaged in sexually abusive behavior are involved in the legal system. However, some do have legal charges related to the abusive behavior and are involved in associated legal proceedings. Assessments of these adolescents require additional considerations because the assessments are part of a legal proceeding and/or the legal process. The ATSA Adolescent Practice Guidelines are not intended to supercede forensic guidelines for evaluation of youth, but do highlight considerations that support best practices in evaluating adolescents who have engaged in sexually abusive behavior who are involved in the legal/court process.

4.0 Practitioners recognize that additional considerations are present when an evaluation is for forensic-related purposes.

4.1 Practitioners familiarize themselves with forensic assessment practice considerations for adolescents, including forensic guidelines and ethics. For example:

- Adolescents have protection and rights in court proceedings and are entitled to legal counsel.

- The preferred practice for risk and needs assessments is for the specialized assessment to be conducted post-adjudication, although there are situations that warrant consideration of a pre-adjudication assessment. Some reasons for consideration of pre-adjudication assessments include:
  - the legal professionals involved in the case are seeking information to inform moving forward with a plea agreement or shaping a plea agreement;
  - the judge is seeking additional information prior to agreeing to a proposed plea bargain; or
  - the court is withholding or delaying action on the charge while providing the adolescent an opportunity for treatment and possible dismissal of the charge.

4.2 Practitioners are sensitive to the ethical, legal, and practice considerations when considering undertaking a pre-adjudication assessment. For example, practitioners should:

- ensure there is definitive information that the adolescent engaged in the sexually abusive behavior, which encompasses:
  - the adolescent's admission to the behavior;
  - the agency, often a child protective agency, officially mandated to be responsible for investigating allegations of sexually abusive behavior and determining whether the behavior occurred, has substantiated that the behavior occurred by the youth (note that behavior substantiated by the investigative agency is different than probable cause legal findings); and/or
  - the behavior was observed by a reliable, responsible witness;
- address concerns about self-incrimination;
- consider the potential for the assessment to directly or indirectly impact the adjudication decision;
- consider the possible impact on the adolescent's civil rights; and

- address questions of reliability and validity of pre-adjudication assessments due to the impact of the adolescent and his/her caregivers' concerns about the potential negative impact of the evaluation, which in turn can influence their level of cooperation or the amount of information they are comfortable sharing.

4.3 Practitioners conducting assessments post-adjudication but pre-disposition need to be sensitive to the adolescent's and caregivers' concerns about the potential for the assessment to inform decisions about removal from the community or other actions, and recognize that these concerns may impact how forthcoming adolescents and caregivers are during the assessment.

4.4 Before conducting the assessment, practitioners ensure that the adolescent and his/her caregiver/guardian/custodian have been made fully aware of, and understand, the potential legal consequences (positive and negative), risks associated with the evaluation, and how the assessment can be used by the court.

Use of Risk – Need – Responsivity in Adolescent Assessments

As discussed earlier, the Risk-Need-Responsivity (RNR) model provides a framework for assessments that inform effective treatment and interventions. Although research related to risk factors regarding nonsexual delinquency recidivism is well developed, studies pertaining to risk factors associated with sexual recidivism among adolescents are limited in number, face methodological challenges, and often have inconsistent results. Thus, there are no consistently reliable predictors of sexual recidivism risk specifically among youth. Despite these limitations, however, RNR assessments provide information that facilitates risk reduction and prosocial development.

Given that adolescents who have engaged in sexually abusive behavior are more likely to reoffend nonsexually than sexually, it is important that assessments address general risk. Assessments should focus on providing a broad, multidimensional assessment of the individual adolescent's treatment and support needs. This includes addressing issues that may be relevant to a youth's risk for sexually abusive behavior, factors related to general risk, and identifying factors that can impact the adolescent's response to interventions. To be effective, assessments also must focus on issues that impact healthy adolescent development and identify strengths and protective factors.

The following guidelines are provided to promote good quality RNR assessments that help inform decisions and interventions to prevent further offending, reduce future victimization, and promote community safety.

Risk – Need Factors

5.0 **Practitioners review the frequency and pervasiveness of risk-related and protective factors, identify dynamic risk factors as treatment targets, and provide risk- and needs-relevant recommendations for effective interventions, treatment intensity, and supervision to reduce the adolescent's risk for reoffending both sexually and nonsexually.**

5.1 Practitioners identify individual, family, and other socio-ecological risk-related factors and protective factors to explore how they may interact to increase or decrease the likelihood of further sexually abusive behavior and/or nonsexual offending.

5.2 Practitioners identify factors potentially impacting engagement and responsiveness to interventions and provide associated recommendations as appropriate. These include, but are not limited to, co-occurring disorders, cultural considerations, learning style, learning problems, intellectual deficits, anxiety, and other factors.

5.3 Practitioners understand that although a greater number of risk factors may suggest increased risk, they need to take into consideration all the information, recognize that many risk factors are dynamic and changeable, identify protective factors that may be present to help reduce risk, and determine if there are any immediate interventions that will help reduce risk.

5.4 Practitioners are aware that research regarding risk and protective factors for sexual reoffending among adolescents is always evolving. As such, practitioners monitor current findings and use relevant multi-disciplinary research findings to inform risk and need assessments. Practitioners also understand that useful information can be found in a variety of journals and other disciplines not specific to sex offenders, and maintain familiarity with advances in developmental, forensic, delinquency, clinical, academic instruction, and other fields of research.

General Reoffending Risk Factors

Static Factors/Historical Factors – Cannot Change

Static and historical factors cannot change. These include:
- prior legally charged offenses;
- unsuccessful prior interventions; and
- out-of-home placement/multiple changes in caregivers.

Dynamic Factors – Can Change

Dynamic factors can change in an adolescent's assessment. These include:
- dysfunctional parenting;
- poor education/vocational skills;
- antisocial peer associations;
- substance abuse;
- poor use of leisure time;

- dysfunctional personality/behavior traits (e.g., aggression, poor frustration tolerance, impulsivity, defiance of authority); and
- attitude, values, and beliefs supportive of crime.

5.5 Risk factors associated with sexual reoffending by adolescents have not been clearly identified and therefore practitioners need to stay abreast of the most current research.

5.6 Research studies focusing on factors that protect against continued sexually abusive behavior by adolescents are limited. There currently is insufficient information to confidently identify protective factors specific to the sexually abusive behavior. However, delinquency and developmental psychopathology research provide a range of factors that may be relevant in facilitating desistance of the sexually abusive behavior. These factors, which warrant consideration and facilitation as potential protective factors include, but are not limited to:

- a healthy sense of personal responsibility and self-efficacy;
- effective emotion regulation and coping strategies;
- self-control and impulse management;
- capacity for problem-solving and effective planning skills;
- a close relationship with at least one competent, caring, prosocial adult;
- positive caregiver and family relationships;
- caregiver monitoring and positive discipline;
- friendships and/or romantic attachments with prosocial peers;
- prosocial investments, such as school engagement;
- involvement in positive activities;
- positive community supports;
- an optimistic future orientation; and
- finding meaning in life (e.g., spirituality).

Responsivity Factors

5.7 Practitioners recognize that effective interventions are tailored to individual and family characteristics and circumstances. Factors that may enhance or impede treatment responsiveness are assessed and documented, and practitioners provide associated recommendations as appropriate. Such factors are relevant for the adolescent and are important for engaging caregivers. The factors include, but are not limited to:

- motivation and readiness;
- cognitive abilities or challenges;
- learning difficulties (e.g., language and information processing challenges, attention difficulties);
- learning style;
- temperament or personality style;
- mental, physical, or behavioral health challenges;
- emotional, psychological, and/or behavioral health challenges;
- religious beliefs;
- biosocial factors (age, gender, ethnic/cultural); and
- familial stability and support.

Assessment Domains

6.0 **Practitioners recognize that assessment of risk, needs, and responsivity are holistic in nature and that risk and protective factors associated with sexually abusive behavior and nonsexual offending are multi-determined. When conducting assessments, practitioners consider individual, caregiver/family, peer, school, and community factors, as well as situational risk and protective factors.**

6.1 Individual domains and areas of assessment may include, but are not limited to:

Developmental History

Factors to consider in the adolescent's developmental history include:

- relevant prenatal, birth, or early history information;
- child maltreatment, trauma, abuse, neglect, changes in caregivers, or placement instability;
- relevant injuries or medical problems;
- education (e.g., school engagement, problem behaviors and consequences, learning challenges, strengths, and positive achievements);
- employment, if relevant;
- social/relationship history (e.g., quality of relationships with family members, positive and/or negative relationships with adults, delinquent and/or prosocial peer associations, and quality and quantity of the relationships or social isolation);
- sexual history and overall sexual functioning (e.g., puberty, sexual knowledge, pornography use [type and frequency], sexting, sexual orientation and gender identity, past sexual activities, current sexual outlets, sex with multiple partners, sexual concerns or problems, masturbatory practices and frequency, fantasies, and sexual attitudes and beliefs);
- illegal substance use/abuse;
- mental, physical, and behavioral health history and current psychological functioning including cognitive functioning, learning strengths and challenges, mental health diagnoses, and medications;
- conduct problems (e.g., delinquency or other rule-violating behavior, aggression, or violence) including age of onset, severity, frequency, and persistence, as reported by official records (e.g., police or school reports), the adolescent, and caregivers; and
- strengths, goals, and motivation for treatment and prosocial living.

Problematic and Abusive Sexual Behaviors

Factors to review include:

- abusive sexual behaviors (current or previous),
  - types of abusive sexual behavior (e.g., hands on, hands off),
  - gender and age of person victimized,

    - relationship to the person victimized,
    - level of coercion or violence used,
    - degree of invasiveness,
    - adolescent's version of the abuse, victim(s)' version(s) by official or victim advocate report(s), adolescent's caregivers' version(s),
    - consequences and responses to sanctions or interventions;
- patterns of offending,
    - antecedents,
    - frequency,
    - duration/desistance,
    - escalation in frequency or severity; and
- other problematic sexual behavior including:
    - excessive preoccupation with sexual fantasies and behaviors,
    - excessive sexual activities such as compulsive masturbation,
    - frequent highly sexualized language,
    - sexualized gestures and behaviors, and
    - persistent sexual interests involving significantly younger children, or coercion or force.

Family Domain

Caregivers and people residing in the home and extended family are important and can provide information on current and historical factors such as:

- reaction and response to the abusive sexual behavior and/or any prior problematic sexual behavior;
- emotional and behavioral stability;
- substance use and abuse;
- child maltreatment/family violence experienced or perpetrated;
- history of child welfare or criminal justice involvement;
- knowledge of normative and non-normative sexual behavior in childhood and adolescence;
- sexual attitudes (e.g., attitudes that justify sexual abuse);
- personal sexual behavior and boundaries (e.g., sexual behavior is private);
- caregiver monitoring/supervision;

- caregiver parenting style and behavior management skills; and
- caregiver strengths, supports, and challenges.

Home Environment

Factors in the home environment include:

- communication and relationship quality among family members;
- rules and routines (clear, stable, developmentally appropriate);
- discipline (consistency, developmentally appropriate);
- privacy boundaries reinforced and supported;
- level of conflict or violence in the home;
- exposure to sexual media or other inappropriate sexual behavior;
- unsupervised access to someone the adolescent could sexually harm;
- encouragement of healthy coping strategies and adaptive skills;
- good safety plans and follow-through; and
- family strengths, supports, and challenges, including extended family and other supports.

Social and Community

Social and community factors may include:

- school engagement;
- school suspensions or expulsion;
- prosocial peers or lack thereof;
- involvement in positive extra-curricular activities (e.g., sports, theatre, debate, music);
- peer rejection, harassment, or bullying by peers;
- negative community response (e.g., ostracism); and
- public registration/community notification.

Assessment Methods

7.0 **Practitioners use reliable and appropriate assessment methods and document them, as well as assessment findings and recommendations, in a written report. Procedures and methods are developmentally appropriate, empirically-informed, and supported by professional guidelines. The depth and breadth of the report will depend on the type of assessment. Any and all limitations are explained within the report.**

7.1 Practitioners use multiple sources of information, to the extent possible and practical, to enhance the accuracy of assessment findings. Sources of information are documented in the assessment report and practitioners note when information of interest could not be obtained. Sources of information include, but are not limited to:

- interviews with the adolescent;
- interviews with caregivers or parents;
- interviews with other relevant collateral sources;
- reviews of relevant records (e.g., police reports, victim statements, and the adolescent's mental health, medical, education, and juvenile court histories);
- structured evidence-based risk and needs assessment protocols; and
- relevant developmentally appropriate and normed measures (e.g., psychological, psychosocial, intellectual), as needed.

7.2 Practitioners act to engage adolescents and their family members/caregivers, as appropriate, in the initial and progress assessments. As part of this process, practitioners afford the adolescent and legal guardians opportunities to make informed decisions about their participation in the assessment. These steps include, but are not limited to:

- using developmentally and cognitively appropriate language tailored to the adolescent's age, developmental maturity, and cognitive functioning;

- ensuring information is understood by the adolescent as well as by his/her legal guardian, such as by asking them to verify their understanding using their own words;
- reviewing and clarifying the nature and purposes of the assessment;
- specifying limits on confidentiality, such as by identifying the persons or entities to whom a report of the assessment will be provided and the circumstances under which information may otherwise be released;
- outlining potential benefits and risks of participating in the assessment and those associated with specific procedures that will be used;
- making it clear that the adolescent and/or guardian may decline to participate in all or part of the assessment, how such decisions will be documented and reported, the potential risks and benefits of such decisions, and referring legal questions to their attorney;
- encouraging and responding to questions posed by the adolescent or his/her guardian about the assessment process; and
- obtaining appropriate, written, informed consent and assent before proceeding with the evaluation, and ensuring that the provided information about the assessment is well understood.

7.3 Practitioners recognize the potential complications and legal issues when disclosures of previously undetected sexual abuse by the adolescent or by others are made during the interview. In some jurisdictions there are legal mandates to report undisclosed child abuse and/or neglect or suspicions of child abuse and/or neglect. In these situations, practitioners will describe how disclosed information regarding previously undisclosed offenses, child abuse and neglect, or imminent intent to harm self or others will be shared and the consequences that might arise from the disclosure.

Assessment Measures

8.0 Practitioners understand that objective and standardized instruments can provide collateral sources of information useful for understanding the adolescent, his/her family, and the social environment in which the adolescent resides.

General Guidelines

8.1 Practitioners use assessment instruments they are trained and qualified to employ. These instruments are used in accordance with the instruction manuals and established assessment procedures and standards.

8.2 Practitioners recognize that assessment measures vary in quality and research support. Practitioners evaluate the psychometric properties of selected measures, identifying issues such as reliability and validity, and favor measures most supported by empirical research. Practitioners explain in the assessment report the strengths and limitations of the selected instruments in non-technical language and ensure that statements about the findings remain within the scope of these measures.

8.3 Practitioners employ tests and measures relevant and appropriate to the referral questions. Practitioners consider the adolescent's age, gender, culture, primary language, cognitive functioning, and other potentially relevant characteristics.

Psychophysiological Measures

Polygraph and plethysmography are physiological measurements designed for use with adults. Their use was extended to adolescents (and younger children) without establishing the measures' scientific validity and without full consideration of their potential for harm. In particular, no research has subjected either measurement to controlled evaluation with relevant comparison groups such as adolescents who have not offended sexually. There are, therefore, no norms against which to compare measurement results, which severely limits their interpretability. More generally, neither measurement has been shown to improve treatment outcomes, reduce recidivism, or enhance community safety. Neither measurement is regularly used outside of the United States. Indeed, some countries have banned the use of one or both measurements with minors.

Ethical concerns raised for both measurements include the potential for coercion and for engendering fear, shame, and other negative responses in adolescent clients. Further ethical concerns relate to the prospect of basing impactful decisions (including those relevant to such things as legal restrictions and/or family reunification) on the results of measurements that are largely unsupported empirically. Separately, plethysmography involves the ethically concerning practice of exposing adolescents to developmentally inappropriate sexual material. Without a clearly identified benefit and with a potential for harm, ATSA recommends against using polygraph or plethysmography with adolescents under age 18. ATSA recommends the use of valid assessment procedures as outlined throughout this section of the ATSA Adolescent Practice Guidelines.

Risk and Needs Assessment Measures

8.4 Practitioners using risk assessment measures are aware that methodological challenges are inherent in research regarding risk assessment tools. Recent meta-analytic findings, however, indicate that several of the most frequently used sexual risk assessment measures, are an improvement over unstructured clinical judgment, relying on individual risk factors or general delinquency risk assessment tools when assessing risks and needs with adolescents who have sexually abused others.

8.5 Practitioners are aware that, when used appropriately and responsibly, research-supported sexual and nonsexual risk and needs assessment measures may assist in identifying relevant factors associated with sexual and nonsexual recidivism and, thereby, can help guide effective interventions.

8.6 Practitioners who conduct risk and needs assessments of adolescents who have sexually abused use one or more of the most empirically supported, independently evaluated, sex-offense-specific risk assessment measures rather than relying on unstructured clinical judgment. As newly developed tools become available, practitioners evaluate relevant professional literature to determine research support before using them.

8.7 Practitioners understand that risk assessment measures that include dynamic risk factors may be most useful for identifying risk-relevant treatment targets and facilitating effective interventions.

8.8 Practitioners understand that, although risk assessment measures can facilitate systematic reviews of relevant risk and protective factors, they do not include all potentially important factors, are not stand-alone risk assessment protocols, and are not substitutes for a thorough assessment of relevant risk and protective factors or case analysis.

8.9 The most empirically supported, independently evaluated, sex-offense-specific risk assessment measures were developed for male adolescents only. When conducting risk and needs assessments with adolescents who have not been a specific focus of these risk measures (e.g., females, adolescents with developmental or cognitive disabilities), practitioners ensure they are knowledgeable of and familiar with the relevant professional literature regarding risk and protective factors and risk assessment with these populations. If practitioners decide to use a measure not specifically designed and researched with adolescents similar to the person they are assessing, they provide a clinical and empirically informed rationale for its use. Practitioners also thoroughly evaluate new risk assessment measures, including psychometric properties, intended for use with a wider population of adolescents who sexually abuse, before using them.

Assessment Conclusions

8.10 Practitioners evaluate the extent to which assessment data (e.g., self-reports, collateral information, tests, measures) converge or diverge and consider possible alternative interpretations of the information before presenting their conclusions. Evaluating multiple sources of information in this manner may enhance the accuracy of assessment conclusions and the usefulness of recommendations.

8.11 Practitioners summarize the strengths and limitations of the assessment, their procedures, and how these factors may have influenced assessment findings. Factors that may influence the accuracy of assessments include the adolescent's legal status, the degree of engagement and motivation to participate honestly, the extent to which collateral sources were available and reported openly and accurately, and the quality of available records, such as whether requested records were obtained or sufficient.

8.12 Practitioners present short-term risk and needs assessment findings that identify individual, family, and other socio-ecological risk and protective factors, and discuss how these factors may interact to increase the likelihood of further sexually abusive behavior, nonsexual offending, or desistance from offending.

8.13 Practitioners realize that attempts to make long-range predictions of future sexually abusive or other types of offending behaviors, especially among adolescents, typically result in mistakenly identifying some individuals as potential recidivists when they are not and identifying others as unlikely to reoffend when they actually may do so.

8.14 Practitioners recognize and discuss the generally low sexual recidivism rate of adolescents who have sexually offended (typically between 5-15%) and discuss factors that may increase or decrease the likelihood of sexual reoffending relative to this base rate.

8.15 Practitioners discuss the adolescent's and his/her family's characteristics and circumstances that may contribute to increasing risk as well as desistance, and those that may facilitate or impede positive treatment responses.

8.16 Practitioners discuss the frequency and pervasiveness of risk and protective factors and the implications of these findings for referring adolescents to appropriate treatments, supervision levels, and treatment intensity.

8.17 Practitioners recognize that risk for reoffending is multi-determined and is influenced by individual, familial, situational, and other factors. Consequently, person-specific risk labels, such as "he or she is a high, low, or moderate risk" should be avoided and, if used, must be used cautiously and include the context.

8.18 Practitioners articulate specific rationales for all conclusions, opinions, and recommendations using language that is readily understandable to consumers of the assessment, such as the adolescent and his/her family.

Assessment Recommendations

8.19 Recommendations are linked to assessment findings. It is inappropriate to use these instruments or the scores derived from them in ways that exceed their intended purposes or to make long-term, unrealistic recommendations.

8.20 Practitioners understand that recommendations are linked to assessed risk, needs, and responsivity factors. Recommendations are designed to promote prosocial development by building on existing strengths, protective factors, and prosocial goals, thereby reducing the risk of future sexually abusive behavior. Practitioners also include suggestions that may facilitate treatment engagement and positive responses.

8.21 Practitioners recommend interventions based on the soundest research available. When evidence-supported interventions are unavailable, recommendations discuss evidence- informed interventions consistent with those that have demonstrated effectiveness with adolescents who have sexually abused or, if appropriate, have engaged in other types of offending; may reduce risk; and successfully promote healthy and prosocial development.

8.22 Practitioners make recommendations that are clear and practical and do not pose unnecessary conditions or undue burdens upon the adolescent and his/her family. Recommended interventions are prioritized to first facilitate safety and address pressing dynamic individual and family case management and treatment needs.

8.23 Practitioners recommend interventions that can occur in the least restrictive setting while maintaining community safety and involve family or other caregivers, unless contraindicated.

8.24 Practitioners recommend intervention strategies tailored to individual, family, and community characteristics to facilitate and maximize treatment engagement and responsiveness. Adolescence is a time of important neurobiological, psychological, and social development. Activities that facilitate prosocial development, such as school engagement, prosocial peers and associations, and positive mentoring relationships, can foster attitudes, skills, and behaviors inconsistent with sexual and nonsexual offending. Although case management or treatment interventions may be needed as well, it is important that they not unnecessarily detract from prosocial activities and normative development. It is important that recommendations foster healthy adolescent development.

F. TREATMENT INTERVENTIONS

Overview

Adolescents who have engaged in sexually abusive behavior are a diverse population in regard to age and maturity level, learning styles and challenges, protective factors, and risk factors associated with reoffending. Interventions with this population should take into consideration these varied factors, as well as the low rates of sexual recidivism and significantly higher rates of nonsexual recidivism. Thus, effective interventions with this population are responsive to the diversity of the population in combination with the need to address sexual and nonsexual risk for reoffending by providing an individualized, holistic treatment framework.

Current studies suggest that cognitive-behavioral, skills-based, and multi-systemic approaches that involve caregivers in treatment have the most research support for youth with a range of behavior problems, including adolescents who engage in sexually abusive behavior. Research suggests that effective treatment interventions are characterized by:

- focusing on dynamic risk factors supported by current research;
- promoting safety while facilitating prosocial and developmentally appropriate skill development;
- using evidence-based interventions that match presenting risk and needs;
- including caregivers and other positive supports;
- addressing risk and protective factors across the adolescent's natural ecologies (e.g., family, peers, school);
- occurring in the natural environment when possible to allow the adolescent and his/her caregivers to practice skills and use social supports in real-life situations;

- tailoring approaches to match individual characteristics and circumstances of the adolescent (e.g., developmental status, learning styles, gender, culture); and
- addressing sexually abusive behavior problems as well as other conduct problems.

Treatment for adolescents who have engaged in sexually abusive behavior and juvenile-justice-involved populations is most effective when delivered in accordance with the evidence-based principles of correctional intervention – risk, need, and responsivity. As a reminder, specific to treatment and interventions:

- Risk informs the intensity of services as well as the level of structure and supervision.
- Need ensures that treatment focuses on factors related to recidivism (general and sexual) as well as individualized needs related to the adolescent's well-being.
- Responsivity supports the use of cognitive-behavioral techniques and skills building while adapting and adjusting approaches and interventions as needed due to factors that impact the adolescent and his/her family's response to treatment.
- Individual and ecological protective factors or strengths are identified and built on within treatment.

Treatment services are best offered and provided along a continuum of care – from community-based (outpatient) interventions to secure residential or correctional-based treatment programs. To be most successful, the level of intensity and restrictiveness of services must match the current treatment and supervision needs which, depending on the youth and his/her family and circumstances, are likely to change over time. Most adolescents can be safely treated in community settings. Residential and correctional settings should be reserved for the minority of youth who present with significant risk factors for recidivism or other treatment needs that cannot be met in community settings.

Interventions such as psychiatric or mental health care, educational services, and community supervision contribute to public safety efforts and promote the overall stability and success of adolescents. Thus, treatment providers often collaborate with other professionals who have various roles and responsibilities working with youth, such as child welfare workers, probation and parole staff, educational professionals, victim advocates, and other professionals. Treatment providers should remain abreast of current research in these fields and align their practices accordingly.

Treatment Provider Qualifications

9.0 **Practitioners remain apprised of contemporary research and engage in professional development activities to ground their provision of research-supported and evidence-based interventions for adolescents who have engaged in sexually abusive behavior.**

9.1 Practitioners have the knowledge and skills necessary to provide effective interventions and adequately address youth responsivity factors and/or special needs by consulting with knowledgeable experts, accessing specialized training, and participating in other professional development activities as needed.

9.2 Practitioners recognize their strengths and limitations with respect to their ability to provide adequately responsive services to youth, and refer youth to providers skilled in addressing specific responsivity factors as necessary.

9.3 Practitioners providing treatment for adolescents who have engaged in sexually abusive behavior collaborate with other professionals including judges, probation and parole officers, child welfare workers, educators, victim therapists, and others to facilitate appropriate information sharing and further the goals of treatment. Such collaboration and cooperation is consistent with and limited to activities and behaviors appropriate to practitioners' professional roles.

9.4 Practitioners encourage, support, and participate in ongoing empirical research efforts designed to identify and refine effective interventions for adolescents who have engaged in sexually abusive behavior and those at risk to sexually abuse others.

Treatment of the Whole Youth

9.5 Practitioners understand that the dynamic nature of adolescent development informs interventions with adolescents who have engaged in sexually abusive behavior. Thus, practitioners use developmentally congruent and appropriate interventions that support maturation in the physical, cognitive, social, emotional, language, and moral domains, thereby supporting healthy adolescent development.

9.6 Practitioners recognize that interventions are informed by the diversity of the population of adolescents who have engaged in sexually abusive behavior. The many factors that contribute to diversity include trauma and chaotic family environments, psychosocial competence, a history of delinquency, personality characteristics, clinical presentation, ecological risks, protective factors, risk for sexual and nonsexual recidivism, and treatment and supervision needs.

9.7 Practitioners appreciate that the evidence for the diverse developmental and dynamic factors associated with adolescent sexually abusive behavior along with the recognition that this population has higher rates of nonsexual recidivism than sexual recidivism, calls for a more holistic, comprehensive treatment plan fostering healthy development and targeting needs related to both sexual and nonsexual conduct problems, as well as other influential factors.

Treatment within the Broader Social-Ecological Approach

9.8 Interventions with adolescents who have engaged in sexually abusive behavior are informed by a social-ecological model that views youth as developing within a complex network of reciprocally interacting contexts and relationships. This model highlights influential factors on multiple levels including the individual level (e.g., the adolescent's personality traits, cognitive abilities, physical abilities, emotional regulation skills); the family level (e.g., stability within the family, parenting style, parents' emotional regulation skills, composition of family); and the community level (e.g., peers, school, neighborhood, economic/recreation opportunities, political influences, and cultural influences). Effective interventions address multiple factors and intervene at multiple levels.

9.9 Practitioners appreciate that parental/caregiver involvement in treatment is critical and that their support and involvement in treatment is needed to provide continuity of care beyond the end of treatment and the supervision and guidance necessary to successfully parent adolescents. Family-based interventions are associated with reduced sexual and nonsexual recidivism.

9.10 Practitioners recognize that treatment interventions with youth who have sexually abused involve the treatment provider working closely with other professionals such as teachers, child welfare workers, juvenile justice professionals, court officers, family treatment providers, and other community support persons to facilitate successful treatment outcomes. These professionals and community support persons may have varying roles and/or responsibilities in attending to the youth's specific risk, needs, responsivity, and protective factors.

Treatment Engagement and Motivation

9.11 Practitioners strive to foster youth and family engagement and internal motivation at the inception and throughout the course of treatment, recognizing that these process-related variables enhance treatment responsiveness and facilitate positive outcomes.

9.12 Practitioners recognize that, although many youth present for treatment as a direct result of legal or other mandates, external motivators alone generally are insufficient for producing long-term change among youth.

9.13 Practitioners understand that a youth's engagement may increase, and resistance may decrease, when the treatment provider, the adolescent, and his/her caregivers collaborate on treatment goals and objectives. As such, to the extent possible, practitioners involve youth and their caregivers in the development of their treatment plans and in identifying realistic goals and objectives.

9.14 When appropriate, practitioners clarify, at the inception of treatment, the adolescent's and caregivers' understanding of the problem(s) for which the youth has been referred to treatment.

9.15 Practitioners recognize that adolescents and their caregivers present with differing levels of internal motivation to change and may have varied types and levels of denial and minimization related to the adolescent's sexually abusive behavior, sexual interests and arousal, and attitudes and beliefs, but that such characteristics do not preclude access to treatment and intervention.

9.16 Practitioners recognize that although offense denial and minimization may impact the adolescent's engagement in treatment, the influence of denial and minimization on sexual recidivism risk has not been clearly established and may vary among adolescent subpopulations.

9.17 Practitioners support youth in being honest in discussing their history and functioning, but acknowledge that it is not the role of treatment providers to attempt to determine or verify a youth's legal guilt or innocence, or to coerce confessions of unreported or undetected sexually abusive behaviors.

9.18 Practitioners routinely explore and seek the adolescent's perspective on treatment and offer feedback on the youth's engagement, motivation, and progress in treatment, or lack thereof.

Therapeutic Relationship

9.19 Practitioners are aware of the strong empirical support for, and recognize the importance of, the quality of the therapeutic relationship in regard to positive treatment outcomes.

9.20 Practitioners recognize that treatment for adolescents who have engaged in sexually abusive behavior is more effective when treatment providers engage youth and their caregivers in the treatment process and interact with them in a respectful, directive, and empathic manner.

9.21 Practitioners provide treatment services in a respectful, directive, and humane manner, and facilitate a therapeutic environment conducive to trust and candor.

General Considerations During Treatment

9.22 Practitioners understand that treatment is guided by ethical principles and current empirical research aimed at maximizing treatment effectiveness, promoting public safety, facilitating prosocial goals for youth, and maintaining the integrity of the profession.

9.23 Practitioners provide treatment in accordance with the ATSA Code of Ethics (2017) and any additional ethical standards, codes, laws, or other expectations for a practitioner's respective profession or discipline. This includes ethical standards pertaining, but not limited, to:

- informed consent;
- specialized training, knowledge, expertise, and scope of practice;
- documentation and retention of records;
- knowledge and application of research;
- confidentiality;
- professional relationships; and
- conduct.

Assessment-Informed Treatment

9.24 Practitioners recognize the importance of individualized, assessment-driven treatment services, and deliver treatment accordingly.

9.25 Practitioners ensure that, prior to initiating treatment services for adolescents who have engaged in sexually abusive behavior, a recent assessment has been completed of the youth's and family's strengths, risk factors for recidivism, and intervention needs.

9.26 Practitioners conduct an assessment designed to identify dynamic risk factors present for a given youth as well as risk and protective factors in the youth's family and social environment prior to developing an individualized treatment plan.

9.27 Practitioners develop and implement an individualized, written treatment plan for each youth outlining clear and specific treatment goals and objectives consistent with the results of a current or recent assessment and other relevant information. The plan informs treatment targets and strategies, duration, and placement decisions.

9.28 Practitioners ensure treatment plans are reviewed and updated routinely, using multiple sources of information (e.g., self-reports, caregiver input, therapist evaluations, behavioral information, legal parties' input, and other assessments). Treatment providers adjust or revise interventions as indicated.

9.29 Practitioners understand that some individuals may present for treatment in the absence of legal or other mandates, and that appropriate services should be made accessible to such individuals with clear informed consent to ensure awareness of mandatory reporting requirements.

9.30 Practitioners working with subpopulations of adolescents who have engaged in sexually abusive behavior (e.g., individuals with intellectual and developmental disabilities, youth with serious mental illness, adolescent females) recognize there is limited research with these subpopulations and ensure they have reviewed the available research and resources specific to the subpopulation they are serving.

Treatment Programming

Practitioners focus treatment interventions primarily on needs related to healthy social, psychological, and cognitive development, and research-supported dynamic risk factors linked to sexual and nonsexual recidivism (e.g., criminogenic needs) over factors that have not been shown to be associated with recidivism. It is important that treatment does not narrowly focus on the sexually abusive behavior, but addresses other assessed risk, relevant needs, and protective factors that can promote prosocial, healthy relationships and healthy lives. Treatment providers also should include treatment targets that enhance therapeutic alliance engagement, and treatment responsiveness.

Treatment Targets

10.0 **Practitioners are aware that the following treatment targets have been associated with sexual recidivism. However, specific targets might not be relevant for an individual youth or his/her family. Moreover, addressing unnecessary targets can reduce both the clinical and cost effectiveness of interventions and may unnecessarily lengthen treatment duration, which could have unintended negative effects.**

Social Isolation/Low Social Competence

10.1 Practitioners deliver services designed to remediate deficits in self-esteem, self-efficacy, and social competence.

10.2 Treatment providers orient their interventions to help adolescents develop skills that can enable them to establish and maintain prosocial relationships with age-appropriate friends and build on strengths in existing relationships. Practitioners understand that parents are key to ensuring youth have opportunities to strengthen prosocial relationships (e.g., by providing welcoming, appropriately supervised environments for youth gatherings).

10.3 When possible while maintaining public safety, practitioners collaborate with other professionals and caregivers to provide the adolescent with opportunities to participate in normative, developmentally appropriate prosocial activities to facilitate prosocial skill development and relationships.

10.4 Practitioners help adolescents develop skills that can enable them to establish and maintain prosocial, intimate relationships with age-appropriate partners.

Attitudes Supportive of Abusive Behavior

10.5 Practitioners recognize that an adolescent's attitudes and beliefs supportive of abusive behavior including sexual abuse (e.g., women enjoy being raped, children can give consent for sexual behavior) are important treatment targets.

Parent-Adolescent Relationships

10.6 Practitioners ensure caregiver-based interventions focus on enhancing the strengths of family relations supportive of prosocial family functioning and healthy adolescent development. Treatment providers enhance caregivers' capacity to effectively supervise and monitor youth behavior, to support responsible youth behavior, and to intervene as appropriate.

10.7 Practitioners collaborate with other involved professionals and caregivers to design safety plans that fit the individual needs of the adolescent and family as well as the safety of the community. Safety plans articulate rules and expectations for the youth; clarify adult responsibilities for supervision, discipline, and reinforcement for appropriate behaviors; and are intended to reduce risk of continued problem behaviors.

10.8 Practitioners identify and design interventions and make appropriate referrals to overcome barriers to positive parenting and to effective youth supervision and monitoring. Such barriers might include caregiver substance abuse, caregiver mental health difficulties, high levels of family stress, and other factors.

10.9 Practitioners develop family-based interventions that focus on enhancing the positive affective aspects of family relations important to healthy families and the favorable social development of adolescents. In particular, the parent-child affective bond is targeted if appropriate. The aim is to improve this bond so youth will internalize a desire for parental approval and so parents will sustain their effort in the face of typical adolescent challenging behaviors and mistakes.

General Self-Regulation

10.10 Practitioners help adolescents learn to self-manage impulsivity and cognitive-emotional states that support or contribute to the potential to engage in sexually abusive behavior as well as other conduct problems.

10.11 Practitioners help adolescents learn and practice stress management, problem-solving and impulse-control skills.

Healthy Sexuality Including Sexual Self-Regulation

10.12 Practitioners recognize that only a subgroup of adolescents who in engage in sexually abusive behavior experience sexual arousal toward prepubescent children, sexual preoccupation, hypersexuality, or arousal to violence that interferes with normative developmental activities and may contribute to sexually harming self or others.

10.13 Research studies regarding interventions that effectively address sexual interest and arousal to children, coercion, or force in adolescents are limited. Practitioners use best practice interventions as described in the literature and, when using behavioral strategies that have limited research support, have appropriate training, obtain consultations, or refer to someone more experienced with this problem.

10.14 Practitioners design interventions that support and promote healthy sexuality including healthy sexual expression and appropriate sexual regulation.

10.15 Practitioners understand that treatment focuses on cognitions that support age-inappropriate and/or nonconsensual sexual interest, arousal, and behavior to assist the youth in enhancing his/her sexual self-regulation.

10.16 Practitioners recognize the need to focus not only on problem sexual behavior but also on the development of social and sexual competencies associated with healthy intimate relationships and sexuality. This includes creating opportunities for learning appropriate social, courtship, and dating skills, and assisting youth in overcoming social anxiety.

10.17 When applicable, practitioners help adolescents find effective ways to minimize contact with persons or situations that evoke or increase a given youth's sexual interests or arousal to children, coercion, and force. For example, an adolescent who sexually abused children would be restricted from babysitting.

Social and Community Supports

10.18 In addition to family and other community support persons, practitioners encourage and help adolescents develop appropriate relationships with prosocial individuals who can act as positive support/supervision contacts. These may include supportive peers, teachers, coaches, and extended family members.

10.19 Practitioners encourage family members, support persons, and involved community practitioners to actively participate in the treatment process as appropriate and to help youth develop and maintain prosocial lifestyles.

10.20 Practitioners assist youth who are transitioning to the community or are already in the community to develop and maintain stable prosocial lifestyles, which are characterized by stable and appropriate living arrangements and educational and leisure activities to help promote community safety.

Nonsexual Delinquency

10.21 Practitioners recognize that some adolescents are likely to benefit from treatment that targets general delinquency factors including values, attitudes, and beliefs supportive of offending, and association with delinquent or negative peers. Practitioners address these issues in treatment when appropriate.

Treatment Modalities

10.22 Practitioners use empirically supported methods of intervention to the extent that such research is available. Currently recommended treatment methods include cognitive-behavioral, skills-oriented, and socio-ecological interventions that target dynamic risk factors, mitigate risk, and enhance protective factors in the adolescent's family and ecology.

10.23 Practitioners appreciate the diversity among adolescents who sexually abuse others, and understand that responsiveness to treatment can vary as a function of a youth's characteristics (e.g., demographics, language, cognitive and social development, mental capabilities, adaptive functioning, and motivation to change).

10.24 When practical, practitioners collaborate with others to deliver services in settings that allow adolescents to practice skills and use social supports in real-life situations, and help the youth learn to generalize and apply those skills to various environments.

10.25 Practitioners understand that for some subpopulations of adolescents who have engaged in sexually abusive behavior, specialized treatment services are best provided subsequent to or in concert with other psychiatric, behavioral, or responsivity-oriented interventions. Practitioners offering specialized treatment collaborate with the providers of such services to ensure that specialized services are complementary.

10.26 Practitioners recognize that services are delivered using a variety of modalities, including psycho-educational, group, individual, family, and multi-systemic approaches matched to the adolescent's and family's intervention needs and responsivity factors.

10.27 Practitioners focus family-based interventions on empowering caregivers to obtain or develop the resources and skills needed to more effectively parent and manage their children's behavior. Commonly targeted caregiver competencies include the ability to provide consistent monitoring and supervision, and efforts to address other factors that might contribute to an adolescent's problem behavior (e.g., associating with delinquent peers and poor school performance). The goal of family-based interventions is to create a context that supports adaptive youth behavior (e.g., relationships with prosocial peers, effective parenting, success in school) rather than a context that encourages antisocial and/or problem sexual behavior. Family-based interventions also aim to improve support of caregivers from other family, friends, and members of the community to help sustain positive behavioral change and healthy development.

10.28 Practitioners working with adolescents who have sexually offended within the family collaborate with caregivers and other professionals involved in the case, including the treatment provider for the victim, in assessing and making determinations about when and if contact, clarification, and family reunification is appropriate.

10.29 Practitioners help adolescents identify and address the factors (e.g., environmental, cognitive, affective, behavioral, relational) that increase or mitigate their risk to engage in sexually abusive behaviors.

10.30 Interventions, including cognitive-behavioral therapies, are used to help adolescents and their parents identify and analyze the factors (e.g., environmental, cognitive, affective, behavioral, relational) that might increase an adolescent's vulnerability to engage in sexually abusive behavior and nonsexual conduct problems. Treatment is used to help adolescents develop and rehearse strategies to effectively manage situations that may increase their risk of sexually abusing or otherwise reoffending. Skill building also strives to increase youth engagement in prosocial activities, including appropriate dating and sexual behaviors.

10.31 Practitioners use established cognitive therapy techniques as well as social learning and other evidence-informed interventions to increase an adolescent's attitudes and beliefs that support prosocial, non-abusive behaviors, while helping the youth manage or decrease any attitudes, beliefs, and values that support offending, abusive, and unhealthy behaviors.

10.32 Practitioners use behavioral methods such as education, modeling, supervised practice, rehearsal, and positive reinforcement to teach adolescents skills that will help them achieve prosocial goals.

10.33 Practitioners help adolescents identify and enhance approach goals (e.g., prosocial interests, skills, and behaviors the youth themselves seek to enhance or attain) as opposed to strictly focusing on managing inappropriate thoughts, interests, behaviors, and risky situations (i.e., avoidance goals).

10.34 Practitioners, when applicable and after careful consideration of the pros and cons, may use specialized and least invasive cognitive-behavioral, behavioral, and/or pharmacological techniques that are informed by the research and known to be associated with reductions in sexual interests and arousal to children, coercion, or force, and associated with improving management and control of sexual impulses.

10.35 Practitioners recognize there are situations in which psychopharmacological intervention is an appropriate adjunct to other interventions or needed for psychiatric stabilization. Practitioners understand that, currently, no medications have been validated as effective interventions for reducing adolescent sexually abusive behavior. Situations which support assessment by a child and adolescent psychiatrist or psychiatric nurse practitioner for consideration of psychopharmacological interventions include:

- Presence of sexual preoccupation with children, coercion, or force, or hypersexual behavior;
- Presence of a mental health diagnosis and symptoms that interfere with healthy functioning such as significant impulsivity or poor self-regulation; and
- Presence of serious emotional disturbance or serious psychiatric diagnosis such as schizophrenia and serious bipolar disorders.

As with any intervention, the use of medications must be developmentally appropriate and the potential benefits associated with psychopharmacological intervention must clearly outweigh the risks, such as adverse side effects. Practitioners must discuss possible risks as well as any limitations regarding the treatment efficacy of the psychopharmacological approach with the adolescent and guardians to ensure the adolescent and his/her caregivers clearly understand the issues and are able to give informed consent to the treatment.

Treatment Process or Discharge

10.36 Practitioners apply the risk and needs principles throughout the treatment process to inform treatment decisions including frequency, focus, and duration of treatment.

10.37 Practitioners recognize that decisions about when an adolescent moves from an out-of-community placement are based on the individual youth's risk and needs, not on a pre-established curriculum or set of objectives. Adolescents are moved to a less restrictive environment and less intensive services when their risk and needs support being safely served outside more restrictive and intensive settings.

10.38 Practitioners recognize and communicate that successful discharge from a treatment program/regimen indicates the adolescent and his/her caregivers, when appropriate, have demonstrated progress related to the goals and objectives of the individualized treatment plan designed to reduce the adolescent's risk to reoffend and increase stability and prosocial behaviors to such a degree that the adolescent's level of risk and needs supports a decrease in intensity of services or the ending of formal treatment. Successful completion does not indicate the individual's risk to reoffend has been eliminated completely.

10.39 Practitioners develop written treatment contracts/agreements (e.g., treatment consent forms) to ensure clarity and agreement among the provider, adolescent, and legal custodian and caregivers, when appropriate. Such contracts address, at a minimum:

- the nature, goals, and objectives of treatment;
- the limits of confidentiality;
- the expected frequency and duration of treatment;
- rules and expectations of treatment program participants;
- responsibilities of the treatment provider;
- risks and benefits of participation and progress;

- consequences of noncompliance with program rules and expectations; and
- criteria used for assessing progress and determining program completion.

10.40 Practitioners routinely use multiple methods in an effort to objectively and reliably gauge treatment progress, particularly with respect to dynamic risk factors. These may include, but are not limited to:

- behavioral information;
- structured, research-supported tests and inventories (as indicated);
- therapist evaluations;
- youth self-reports; and
- family and other collateral reports.

10.41 Practitioners routinely review the adolescent's individual treatment plan and clearly document in treatment records the specific and observable changes in factors associated with a youth's risk to recidivate, or the lack of such changes.

10.42 Practitioners review the adolescent's and family's progress toward attainment of goals and objectives related to decreasing risk and promoting healthy functioning when making decisions about successful discharge from treatment. An adolescent who is successfully discharged from treatment generally:

- has developed recognition of antecedents, behaviors, and consequences related to past sexually abusive behaviors and has a plan for avoiding, refusing, or altering such antecedents;
- demonstrates functional coping patterns when stressed;
- demonstrates the ability to manage anger, frustration, and unfavorable events;
- demonstrates self-protection skills;
- demonstrates prosocial relationship skills;

- has replaced inappropriate (or, in the case of social isolation, the absence of) peers and activities with prosocial peers and appropriately monitored prosocial activities;
- has developed, with his or her family, an understanding of appropriate dating, romantic, and sexual behaviors, and how these might change over time;
- has developed, with his or her family, a plan for successful school involvement; and
- when sexual interests of children, coercion, or force contributed to past sexually abusive behaviors, has developed a plan for addressing the occurrence of inappropriate sexual thoughts, fantasies, or behaviors.

10.43 Practitioners help caregivers develop enhanced capacity to effectively supervise and monitor youth behavior, support and reinforce responsible youth behavior, and consistently apply sanctions for inappropriate behavior.

10.44 Practitioners evaluate treatment progress within the context of a thorough understanding of the adolescent's individual capacities, abilities, vulnerabilities, and limitations. Associated recommendations should reference these factors and aim to stay within the bounds of what is likely or possible for the individual youth.

10.45 Practitioners providing community-based treatment recommend more intensive treatment and/or supervision if an adolescent experiences significant difficulties managing identified risk factors for sexual and nonsexual offending in a way that jeopardizes community safety.

10.46 Practitioners prepare the adolescent and his/her family for discharge from treatment. This may include a gradual reduction in frequency of contacts over time as treatment gains are made, booster sessions to reinforce and assess maintenance of treatment gains, and coordination with future service providers.

10.47 Practitioners are clear when communicating with youth, other professionals, and the public that some adolescents may require ongoing management of their risk and treatment needs.

10.48 Practitioners provide adolescents, caregivers, support persons, and appropriate professionals involved in ongoing case management with written information that includes follow-up recommendations for maintaining treatment gains.

10.49 Practitioners immediately notify the appropriate party(ies) if a legally mandated youth discontinues treatment or violates a mandated condition of parole, probation, or treatment.

G. SPECIAL POPULATIONS

Overview

In general, there is a relatively small body of research that has examined the assessment, treatment, and treatment outcomes of specific subpopulations of adolescents with sexually abusive or problematic behaviors. Due to this limited base of empirical knowledge, it is important that practitioners familiarize themselves with the research available in relation to specific subpopulations (e.g. adolescent females, developmentally delayed adolescents, adolescents diagnosed with Autism, and adolescents with co-occurring mental health problems), and then augment that knowledge with information gathered from research examining broader developmental, mental health, educational, behavioral, and treatment issues related to these populations. It also is important, given the limited research available, that practitioners are appropriately cautious about making broad references or comparisons regarding these adolescents to other groups of adolescents with sexual behavior problems when using research, assessment tools, or treatment programs that did not consider these specific populations in their design, normative samples, or outcomes.

Whenever possible, practitioners should make efforts to educate individuals involved in the decision making, education, and care of these adolescents about the current level of knowledge regarding sexual behavior problems in these populations as well as additional research that can help in making informed decisions involving assessment, treatment, and safety.

Assessment

11.0 Practitioners recognize the relatively limited research on the potentially unique characteristics, risk and protective factors, and intervention needs for special needs populations of adolescents with sexual behavior problems and the associated implications for the reliability and validity of assessments.

11.1 Practitioners conducting assessments on adolescents with special needs who have engaged in sexually abusive or problematic behavior have specialized training regarding these special needs populations.

11.2 Practitioners conducting assessments recognize that assessment instruments developed for and used with adolescent males who sexually abuse may not be appropriately normed, valid, or reliable for specific subpopulations of adolescents who engage in sexually abusive or problematic behavior. If such instruments are used, the practitioner reports the strengths and limitations of these measures in the particular case.

11.3 Practitioners conducting assessments select the most reliable and valid assessment instruments and procedures appropriate to the adolescent's age, gender, culture, language, developmental and intellectual functioning, and other differences.

11.4 When providing assessment results, practitioners note in the report any limitations or biases of using instruments or procedures that were not developed to take into account an adolescent's age, gender, cultural background, socioeconomic status, education, language, or level of intellectual functioning.

11.5 Practitioners strive to meet the special needs of adolescents with developmental, learning, or physical impairments during assessments (e.g., using taped versions of questionnaires, modifying terminology/language on self-report instruments). Practitioners must document the reasons and the rationale for using alternative testing methods. In addition, it should be noted that these special accommodations might have an impact on the reliability and validity of instruments that are typically self-administered.

Treatment

12.0 Practitioners appreciate the diversity among adolescents who have engaged in sexually abusive or problematic behaviors, and recognize that responsiveness to treatment can vary as a function of client characteristics such as gender, cultural background, developmental level, cognitive capabilities, and adaptive functioning.

12.1 Practitioners recognize that not all treatments have been developed or evaluated with various subpopulations of adolescents who have engaged in sexually abusive behaviors. Practitioners must identify the limitations of different treatment approaches with these various populations prior to initiating treatment.

12.2 Practitioners assess and identify responsivity factors such as comprehension, cognitive capabilities, executive functioning skills, adaptive functional level, and other variables that may impact an adolescent's ability to maximally benefit from different approaches to providing sexual-abuse-specific treatment.

12.3 Practitioners adjust approaches and interventions to match adolescents to appropriate services based on identified responsivity factors, to maximize the benefits of treatment.

12.4 Practitioners make serious efforts to equip themselves with the knowledge and skills necessary to adequately address adolescents' responsivity factors and/or special needs by consulting with knowledgeable others, accessing specialized training, and participating in other professional development activities.

12.5 Practitioners recognize their strengths and limitations with respect to their ability to provide adequate, responsive services to some subgroups of adolescents and, when necessary, refer clients to providers skilled in addressing specific responsivity factors.

12.6 Practitioners understand that, for some subpopulations of adolescents, sexual-abuse-specific treatment services are best provided subsequent to or in concert with other psychiatric, behavioral, or responsivity-oriented interventions. Practitioners offering sexual-abuse-specific treatment need to collaborate with the providers of such services to ensure that sexual-abuse-specific services are optimized for the adolescent being treated.

12.7 When providing sexual-abuse-specific treatment, practitioners work closely with family members, educators, and other community support persons who can facilitate successful treatment outcomes because of their abilities to attend to these adolescents' specific needs.

H. SUPPORTING REHABILITATION

Overview

As stated earlier in this document, public health and public safety are both jeopardized by ineffective or misguided public policy and criminal justice efforts. This is especially true for adolescents in jurisdictions where policies designed for adults have been applied to juveniles.

The putative aim of subjecting adolescents to adult-based sex crime laws and policies is to reduce the risk posed by these youth to their communities. However, research findings indicate that rehabilitative efforts are effective with most adolescents and that therapeutic interventions, rather than social control strategies, are not only more promising and more successful, but more cost-effective as well. In general, what is good for public health and public safety is often the very same set of conditions that promote healthy adolescent development.

13.0 Practitioners understand and recognize that effective public policy and practice for adolescents who have engaged in sexually abusive behavior involves a strong rehabilitative focus.

13.1 Practitioners appreciate that support of a rehabilitative approach is consistent with juvenile justice philosophies in most countries and recognize adolescence as a time of hope and opportunity for positive outcomes.

13.2 Practitioners recognize that, while at times legal system sanctions may be warranted, such sanctions should not be applied in isolation and without consideration of those interventions needed to facilitate broader prosocial development. Practitioners recognize the possible long-term negative consequences if sanctions are applied in isolation.

I. APPENDIX: SPECIAL POPULATIONS

Adolescent Females

While there is general agreement that females engage in sexually assaultive and abusive behavior far less frequently than males, reported crime statistics have indicated a consistent rise in the number of sexual offenses committed by females since the late 1990s. Despite this rise, there also is the belief that sexually abusive behavior perpetrated by females is under-reported.

Research that has examined issues related to females who have engaged in sexually abusive behavior has been very limited and has been hampered by small sample sizes. The research that has been done on females who commit sexual offenses has largely focused on adult females.

The limited knowledge base that does exist would appear to indicate that, like adolescent males who engage in sexually abusive behavior, adolescent females who engage in sexually abusive behavior are a heterogeneous group. However, research has suggested that, as a group, adolescent females who engage in sexually abusive behavior may differ from male counterparts in some key characteristics:

- A higher percentage of females who engage in sexually abusive behavior have a history of sexual victimization.
- Females who have been sexually victimized generally have been victimized earlier than males and are more likely to have had more than one perpetrator.
- A higher degree of family dysfunction has been reported in the homes of adolescent females who have sexually abused when compared to males, including physical and emotional abuse and parents (especially mothers) with serious mental health problems.

- Females who engage in sexually abusive behaviors evidence a higher incidence of co-morbid mental health problems than males. In particular, females show a higher incidence of internalizing mental disorders such as PTSD and depression.
- Adolescent females have higher rates of suicidal behavior, suicidal ideation, and other self-harming behavior (e.g., cutting) than adolescent males.
- Adolescent females may have higher rates of co-offending or group offending behavior than adolescent males.
- Adolescent females are more likely than males to engage in sexually abusive behavior toward young children in the family or children with whom they are familiar.
- Adolescent females are more likely than males to target both genders and are more likely to commit offenses within the context of child care roles.

Assessment and treatment approaches for adolescent females largely have been modeled on the approaches developed for males. While research suggests there are similarities in the treatment needs for both genders, treatment programs for adolescent females that are not informed by the different dynamics and trajectories of female development are likely missing important elements that support healing, growth, and personal efficacy. There presently are no empirically supported risk assessment instruments designed specifically for adolescent females who have engaged in sexually abusive behavior. The use of risk assessment instruments that were developed based on risk factors found in male populations may misinform assessments and therefore should be used cautiously or not at all. Practitioners assessing adolescent females should consider using information and assessment measures that examine broader personality and mental health issues, research on resiliency and protective factors, and research on risk factors associated with adolescent female delinquent behavior, as well as the limited research available regarding risk-relevant factors for females who have engaged in sexually abusive behavior.

Research on adolescent delinquent behavior identifies a number of factors that can inform risk assessment for female adolescents:

- Childhood onset of physical and relational aggression and oppositional behavior to adult authority for females tends to lead to an antisocial trajectory that follows into adulthood.
- Early onset of menarche (before the age of 11) appears to be positively correlated with the development of adolescent onset behavioral disorders.
- The co-morbidity of internalizing disorders with externalizing behavioral difficulties presents as a greater risk for developing conduct disorder than externalizing behaviors alone.
- Depending on the nature of the relationship, the development of a long-term, intimate relationship may actually present as a risk factor for females rather than having the result of providing greater stability, as is frequently evidenced by males.

There are few treatment programs that have been specifically designed for adolescent females who engage in sexually abusive behavior. However, research findings do support that certain treatment variables should be highlighted when providing services to this population:

- Issues of early victimization and trauma appear to be very prevalent for adolescent females who sexually offend, so particular attention to victimization issues using a trauma-focused treatment approach would seem warranted.
- Internalizing disorders such as depression, post-traumatic stress, and anxiety disorders appear to have a high level of co-morbidity in these adolescent females and should receive specific attention and treatment.
- Issues of suicidality and self-harming behavior need to be actively monitored and addressed.
- Practitioners treating adolescent females who have sexually offended need to be knowledgeable about gender-specific developmental processes and adapt treatment interventions and treatment modalities accordingly.

- A central component of treatment should focus on increasing self-efficacy by developing skills and addressing social and cognitive assumptions.
- Families need to be actively engaged in treatment as a means for addressing issues of safety, attachment, and relational stability.

Although many of the issues that need to be addressed when working with adolescent females who have engaged in sexually abusive behavior are similar to those that are addressed with males (e.g., developing healthy and prosocial relationships, healthy sexuality, effective social and coping skills, and emotional regulation), developmental research suggests that the dynamics and pathways involved in issues like safety, attachment, peer relationships, healthy sexuality, family relationships, accepting responsibility, self-efficacy, and competence are different for females than for males. Even within this framework, different cultural roles and attitudes regarding women will be important aspects in understanding both the etiology and treatment needs of this population.

Adolescents with Intellectual Disabilities

Adolescents with intellectual disabilities or Intellectual Developmental Disorder are identified as individuals who experience deficits in both intellectual functioning and day-to-day adaptive functioning. Difficulties in intellectual functioning frequently are recognized as problems with academic learning, but also reflect problems with reasoning, abstract thinking, problem solving, and judgment. Adaptive functioning deficits indicate a failure to meet developmental standards for independent functioning and personal responsibility in multiple settings including home, school, and the community. These deficits can include problems in communication, social participation, and independent living. It is important that practitioners and the systems they work within recognize the essential role of adaptive functioning skills in determining the needs of the adolescents they treat and do not solely use IQ scores to determine the presence of intellectual disabilities or the availability of necessary resources and supports for this population.

Many of the adolescents identified as having intellectual disabilities actually may be presenting with a range of developmental disabilities or specific learning problems (e.g., Autism Spectrum Disorder, neurobehavioral disorders associated with prenatal alcohol exposure, or communication disorders). Each of these developmental disabilities can manifest through a variety of behavioral and cognitive difficulties, and care should be taken when determining appropriate and effective assessment and treatment interventions based on the particular needs of the individual.

It is unclear what percentage of adolescents engaging in sexually abusive or problematic behavior meet the criteria for intellectual disabilities. The prevalence of intellectual disabilities has been reported as being approximately 2% in the general population, and approximately 15% among children ages 3 – 17. It is clear, however, that adolescents with intellectual disabilities and other types of specific developmental or learning problems are over-represented in the juvenile corrections system, with nearly 10% meeting the criteria for intellectual disabilities and almost 40% experiencing specific learning problems.

One factor to consider is research indicating that children with intellectual and developmental disabilities are at a significantly greater risk for experiencing maltreatment and sexual abuse than individuals without disabilities. Research has shown that early histories of abuse and neglect, exposure to violence, and other adverse childhood events can lead to adolescents engaging in a range of problematic behaviors that may include sexually abusive behavior. Many adolescents who are evaluated and treated for sexually abusive behavior may present with histories of maltreatment and trauma.

There is mounting evidence that the early experiences of trauma, neglect, and attachment disruptions may have a significant neurodevelopmental impact on children and adolescents, with earlier and more pervasive trauma experiences creating broader functional difficulties. Possible neurodevelopmental impacts, learning problems, and developmental disabilities are important factors to consider in the behavioral dynamics and responsivity to treatment with all adolescent clients, not just those with intellectual disabilities.

Practitioners providing assessment and treatment services to adolescents with developmental delays should recognize the limitations of assessment tools and treatment approaches that were not developed or normed for this population. Practitioners providing services to this population also should:

- recognize the need to adapt the content of assessment and treatment materials to the cognitive level and language-based abilities of their clients;
- regularly incorporate Adaptive Behavior Assessments and Functional Behavior Analysis into their assessment protocols and treatment interventions;
- recognize the need for multi-modal treatment interventions that rely less on language-loaded treatment approaches and incorporate more visual, experiential, and kinesthetic learning on a consistent basis;
- appreciate that possible difficulties and deficits in processing speed and working memory may necessitate the frequent repetition of psycho-educational treatment content and the regular practice of newly acquired skills before they can be integrated and used effectively; and
- recognize the importance of educating families and other care providers about the developmental needs and challenges these adolescents present.

Since developmental delays and intellectual deficits can be quite varied, practitioners need to provide individualized approaches to assessment and treatment for developmentally delayed clients. In addition to the concerns more typically addressed in the assessment and treatment of youth with problematic sexual behavior, specific attention may be needed for certain key areas, such as:

- the extent of the adolescent's knowledge regarding general social rules and conventions related to sexual behavior;
- the adolescent's ability to distinguish between acceptable and unacceptable sexual partners;
- the extent and source of the adolescent's sexual knowledge;
- the adolescent's understanding of the potential consequences for sexually abusive behavior for self and victims;
- the opportunities the adolescent has for expressing his/her sexuality in a non-problematic manner; and
- the support or limitations offered to the adolescent from his/her family or system care providers for the development of sexual knowledge and the expression of healthy sexual behavior.

More comprehensive guidance and resources regarding the assessment and treatment of adolescents with intellectual and developmental disabilities can be found in the ATSA Assessment and Treatment of Adolescents with Intellectual Disabilities Who Exhibit Sexual Problems or Offending Behavior 2015.

Adolescents with Co-Occurring Mental Health Problems

Studies with populations of nonsexual offending adolescents have found a high incidence of mental health diagnoses and a prevalence of co-occurring disorders (i.e., more than one mental health diagnosis) in the general delinquent population. Studies generally have identified a higher incidence of externalizing disorders (e.g., Conduct Disorder, Oppositional Defiant Disorder) than internalizing disorders in the general delinquent population, although some studies have found a high level of both externalizing and internalizing diagnoses among adolescents who were incarcerated.

Research with juvenile offenders also has cited a significant level of ADHD and substance abuse disorders in these adolescents. Research provides strong support in regard to generally delinquent adolescents that specific mental disorders and their co-morbidity increase the risk of aggression secondary to emotional and self-regulatory symptoms. When psychiatric disorders are addressed as part of an overall treatment intervention, outcomes for these adolescents appear to improve.

Studies have included examinations of the mental health diagnoses of adolescents who sexually abused as a subgroup of the general delinquent population, and have explored differences in subgroups of sexually abusive adolescents. A recent large meta-analysis found the following prevalence rates among adolescents who have sexually offended:

- 69% at least one mental disorder,
- 51% Conduct Disorder,
- 44% at least two mental disorders,
- 30% at least one Substance Use Disorder,
- 18% Anxiety Disorder (PTSD = 8%),
- 14% ADHD, and
- 9% Affective Disorder.

Previous research has found differences in subgroups of adolescents who have engaged in sexually abusive behavior. Externalizing problems were more common in offenders with same age and older victims, while adolescents with child victims were more likely to manifest internalizing problems. Studies have not found a direct connection between mental health diagnoses and sexual recidivism for adolescents who engage in sexually abusive behavior.

Some adolescents present with serious emotional disturbance such as schizophrenic and serious bipolar disorders. This results in additional considerations with a priority on psychiatric stabilization and ongoing monitoring of stability. Serious emotional disturbances impact the adolescent's overall functioning as well as approaches and timing of interventions.

With this research in mind, professionals working with adolescents who engage in sexually abusive behavior should:

- Assess for the possibility of co-occurring disorders and provide appropriate treatment interventions as warranted.
- Understand that psychiatric disorders may be present throughout childhood or may develop during adolescence, reflecting the need to remain attentive to the assessment of emerging symptoms.
- Appreciate that the discovery or disclosure of sexually abusive or problematic behavior can be a significant source of stress and disruption for the adolescent and his/her family, thereby triggering serious mental health issues.
- Seek additional clinical support to address diagnostic and treatment issues that are outside the realm of the practitioner's professional experience, clinical expertise, or professional role.
- Develop an open and collaborative relationship with a child or adolescent psychiatrist or psychiatric nurse practitioner who would co-treat clients when psychopharmacological intervention is warranted.
- Consider the presence of a psychiatric diagnosis as an important "responsivity" factor when determining the sequencing of treatment interventions, the level of treatment resources necessary, the most effective types of treatment modalities, and the level of structure and supervision a client may require for the purpose of safety and successful treatment outcomes.

J: APPENDIX: PUBLIC POLICY

History of Public Policy Development

Modern, more restrictive, sex crime laws and policies have been developed and adopted with increasing frequency since the 1980s, most readily in the United States, but also in Canada, Australia, and the United Kingdom. In the early 1990s, public fear swelled during a sharp increase in criminal behavior in the United States. During this time, researchers predicted that society was developing juvenile super-predators. As a result, policies were enacted that treated adolescents like adult offenders and the number of juvenile correctional treatment facilities grew significantly. There also was increased public awareness and concern with what the public viewed as a chronic prevalence of sexual aggression and sexual victimization being uncovered as laws were enacted that required reporting any suspected child victimization.

Many of the policies developed during this time, which were aimed at adolescents who sexually abuse, failed to include any effective policy characteristics. Rather, policies originally intended to address adult sexual offending often broadly targeted youth without consideration of their developmental status. These same policies failed to substantively include adolescents' parents/caregivers, and failed to meet any of the RNR principles. Some of these policies continue to be perpetuated in the presence of empirically rigorous research attesting to policy failure and/or in light of strong theoretical arguments that the policy impedes rather than promotes youth prosocial development.

No one is served by poor policy – not the people victimized by sexual abuse, not the adolescents who have sexually abused, and not community members whose safety remains unchanged at best. Moreover, ineffective policies waste limited resources that could be directed to better interventions.

Supporting Effective Policies

ATSA works toward amending or eliminating harmful policies as new research and data emerge on effective interventions. ATSA practitioners are encouraged to inform policy makers about strategies for aligning existing or proposed policies with empirical research support, and to advocate for an end to ineffective policies, especially where the potential for harm exists.

At a minimum, ATSA promotes these four fundamental aspects of effective policy:

- Effective policies are purposefully designed with the twin aims of (1) promoting the prosocial development of youth and (2) effectively mitigating the risk posed by youth to their communities. Related to these twin aims, effective policies are developed by first considering all relevant information – including scientific findings – and developing testable aims and outcomes that are subsequently evaluated to ensure those aims are accomplished.

- Effective policies for adolescents are specifically designed for this age group versus adults. Relatedly, these policies are consistent with the aims of juvenile justice, support rehabilitation not punishment, and recognize that adolescents are developmentally immature relative to adults. Likewise, such policies recognize that, to a greater degree than is true for adults, adolescent behavior is influenced by external factors, especially family, peer, and school influences, in addition to internal factors such as impulsivity. Finally, effective policies recognize that most youth will age out of delinquent behaviors as they mature and develop into adults.

- Effective policies acknowledge the importance of parents and other caregivers to the successful development of youth and stipulate that caregivers should be substantively involved in interventions addressing adolescent sexually abusive behaviors and other behavioral and mental health problems, unless contraindicated.

- Effective policies are consistent with the principles of risk-need-responsivity (RNR) by:
  - focusing primarily on adolescents with the greatest risk and fewest protective factors;
  - identifying and addressing intervention needs pertaining to valid recidivism risk factors; and
  - being responsive to youths' abilities, capacities, and learning styles.

Supporting Research-Based Policies

From a developmental standpoint, the commission of a violent or sexual offense by an adolescent often is treated by mental health and social service systems as a marker of developmental or mental health problems indicating a need for intervention. Penal policies that extend adult laws to youth treat such offenses as a marker of increased culpability and disregard developmental considerations or rehabilitative needs. By subjecting youth to adult-like procedures, penalties, and social control policies, society is in effect saying these youth are more adult-like than their nonoffending peers or adolescents who commit other types of crimes. By comparison, no policies extend adult legal privileges such as voting and driving down to underage youth regardless of their exemplary behavior, presumably due to recognition of the fact that even smart, well-behaved adolescents are not the same as adults.

The body of evidence fails to support any community safety effect of adult-based juvenile sex crime policies. With respect to registration and notification, neither policy deters first-time juvenile sex offenses or juvenile sexual, violent, or nonviolent recidivism. Instead, these policies are associated with changes in juvenile case processing decisions such that more juvenile sex offense cases are dismissed, diverted, or pled to non-sex-offense charges. In fact, on average, registered youth have low sexual offense recidivism rates indistinguishable from nonregistered youth. Registration and notification also appear to increase the risk of adolescents sustaining new nonviolent charges but not new nonviolent convictions, suggesting an unfair surveillance effect on registered but not nonregistered youth. In addition, state and federal systems designed to distinguish (or tier) adolescents into higher and lower risk categories fail to do so accurately. Even when these classification systems are empirically based – which is rarely, if ever the case – given the rapid changes associated with adolescent development, these classification systems are likely to reflect short-term risk at best.

Existing research, while scant, on civil commitment policies has found that civil commitment procedures fail to accurately identify adolescents at high risk of recidivism. There is an even greater dearth of published studies examining residence restrictions as applied to adolescents. However, there is near-unanimity across numerous adult-focused studies that registration laws fail to support community protection and prevention goals.

There is no reason to suspect that adolescents would be less adversely affected than adults by residence restrictions and, indeed, adolescents have fewer resources and less control over those resources with which to address the problems posed by residence restrictions. It seems particularly contrary to healthy and prosocial development to apply residence restrictions to adolescents – to require that adolescents reside further away from public schools and other places where their peers congregate. Rather, they ought to be encouraged to attend schools and congregate with prosocial peers if they are ever to reach their full potential.

In summary, while juvenile sex crime policies might have been crafted to mitigate risk, the available evidence fails to support this aim. Moreover, these policies were neither originally developed nor reasonably adapted specifically for adolescents. Such policies fail to promote youth prosocial behavior, fail to consider the importance of parents/caregivers, and are inconsistent with the principles of RNR. Therefore, it is ATSA's position that youth should not be subjected to these policies. Specifically, civil commitment, sex offender registration, public notification, and the collateral consequences triggered by these policies (e.g., residence, education, and employment restrictions) should not apply to youth adjudicated delinquent as minors. Moreover, ATSA encourages the revision of policies that require extensive periods of incarceration or the transfer of underage youth to adult court, particularly policies that are implemented without discretion (e.g., automatic transfers or waivers based on charge or a combination of charges and the adolescent's age) except in all but the most extreme cases.

Rather, policies would be better crafted if the basic assumption was that adolescents should not be treated like adults. Then, in the rare cases when it appears that an adolescent cannot be safely maintained within juvenile-specific systems (e.g., juvenile justice, child welfare, public education), decisions could carefully weigh the risks to the community versus the risk to the individual adolescent who faces adult sanctions. Such rare cases might involve youth whose abusive behavior persists despite the availability and provision of evidence-informed treatment.

Beyond Juvenile Justice: Decisions Related to Supervision, Placement, Education, and Disclosure

Professionals who provide services to adolescents who have engaged in sexually abusive behavior make or influence decisions regarding a host of considerations in the lives of these youth. Quite often, such decisions are made in the absence of formal policy, although local standards of practice may have evolved around a set of unwritten rules. Moreover, written and unwritten policies that guide supervision, placement, education, and disclosure decisions often seem to be constructed around broad and faulty assumptions and generalizations such as "all adolescents who sexually abuse are likely to do it again," or "perpetrators should never live in a home with their victims."

Good practice regarding adolescent non-judicial decision making should be premised on an individual adolescent's risk, needs, and responsivity, and conducted on a case-by-case basis. Indeed, good practice should involve the same four broad considerations as effective judicial policy: (1) minimizing risk while maximizing a youth's potential for prosocial development; (2) consideration of the developmental status of the youth and recognition of the speed with which such status can change, usually for the better, as adolescents age into adulthood; (3) recognizing the inherent importance of an adolescent's parents/caregivers in guiding youth behavior; and (4) adhering to principles of risk, needs, and responsivity. In addition to these broader guiding principles, several general considerations are relevant for decision making regarding supervision, placement, education, and peer activities. These include:

- Giving more weight to recent behavior than past behavior. When considering placement, recent offense-free behavior in the community could help support remaining in the community. The same logic applies for remaining in school. When considering a return to school, recent examples of appropriate behavior during structured and supervised activities could weigh in favor of re-enrollment.

- Considering distress caused to other youth. A person might experience distress if exposed in school or at home to the adolescent who sexually abused him/her. In these situations, the safety and well-being of the victim is the priority. A team approach helps ensure that all aspects of the situation are taken into consideration and allows for a plan to be developed that addresses concerns and needs.

- Considering caregivers' ability to ensure the safety of all youth in their care. Simply assuming that parents are unable to monitor an adolescent who has sexually abused is insufficient. Rather, concern about parental capacity to effectively supervise and support the adolescent's treatment should trigger the provision of services designed to improve that capacity so as to increase the likelihood a youth can return to his/her family.

- Considering out-of-home or out-of-community placement. The individual youth's risk and needs inform the decision about whether an out-of-home or out-of-community placement is needed. In cases in which the abuse occurred in the home, safety as well as the impact on the victim's well-being are key considerations. The abusive adolescent's risk and needs may warrant out-of-home or out-of-community placement. In addition, at times serious psychiatric issues (e.g., suicidal or psychotic symptoms) support hospitalization or residential placement for stabilization. When a youth is removed from the home and/or community, it is important that discharge planning from the placement is initiated at the time of admission. Early planning supports successful re-integration into the community and/or home. Supervision, activities, and intensity of continued interventions are based on the youth's progress and functioning at the time of discharge.

As with all clinical populations, and as emphasized throughout this document, adolescents who sexually abuse are diverse, and practitioners' responses should be calibrated to each youth's individual strengths and needs, as well as the strengths and needs of their caregivers. ATSA advocates against blanket and one-size-fits-all policies that treat all youth adjudicated of a sexual offense in the same manner, whether these pertain to supervision (e.g., mandating intensive probation for all such youth), placement (e.g., mandating out-of-home or residential treatment for all such youth), education (e.g., automatic suspension or expulsion or refusing to re-enroll any youth with a sexual offense), and peer activities (e.g., broadly prohibiting appropriately supervised prosocial activities with peers or family).

There certainly are individual circumstances warranting intensive supervision, out-of-home placement, private tutoring, and/or limited access to certain peers or family members. Yet the low sex offense recidivism rate of adolescents adjudicated for sexual offenses indicates that most such adolescents can and should be placed in their own communities and ideally in their own homes. When considering decisions for individual youth, decision makers are encouraged to consider both the low overall risk of recidivism posed by the adolescent who caused sexual harm coupled with the fact that risk is modifiable with evidence-based interventions.

Moreover, as noted in earlier sections of this document, even adolescents with many risk factors can benefit from remaining within their communities to access evidence-based treatment, provided that sufficient supervision is in place to keep them and others safe. When restrictions are placed on adolescents' opportunities regarding where they may live, attend school, and socialize, such decisions should be accompanied by the provision of free or affordable evidence-based treatment designed to mitigate risk, improve prosocial behavior, improve caregiver capacity, and return the adolescent to settings typical of normatively developing youth as quickly as possible.

Decisions Related to Disclosure of Youths' Status

Since the advent of specialized treatment for adolescents who sexually abuse, determining who, if anyone, needs to be informed about an adolescent's status as a sex offender has been an area of consideration and discussion. Widespread disclosure of an adolescent's status is sanctioned and even required by some states' notification policies despite a body of evidence that fails to support these policies.

Likewise, research points to the negative effects of labeling youth. Thus, in general, information from juvenile justice, treatment, and other agency records, including the records of adolescents who have sexually offended, should be treated confidentially. However, there are some situations in which disclosing accurate information, with an appropriate release of information, about a youth's prior offense history and related recommendations is warranted. For example, foster care parents require comprehensive knowledge regarding each youth's individual strengths and needs to be best able to provide safety and support.

When developing recommendations regarding disclosure, decision makers should consider:

- the reason disclosure is being considered,
- the person to whom disclosure is being considered,
- the harm that disclosure is thought to avert,
- the harm that disclosure might cause, and
- what additional information to include to increase the usefulness and decrease the potential harm when disclosure does occur.

With these considerations in mind, ATSA further emphasizes that information is shared only on a need-to-know basis.

Policy Conclusions

ATSA's mission is the prevention of sexual abuse through the promotion of effective practice and policy. At a minimum, effective policies:

- Promote interventions that are purposefully designed for adolescents to mitigate risk and promote social development,
- Substantively involve parents and other caregivers, and
- Are premised on RNR principles.

Many policies – both written and unwritten – that guide how practitioners intervene with youth who have sexually abused fail to adhere to fundamental standards. In isolation, these policies are largely ineffective and potentially harmful. As stated earlier, no one is served by poor policy. ATSA practitioners should seek to replace such policies with those that effectively meet the needs of youth, the people who were victimized, and our communities.

ATSA recognizes the mutual and exponential benefits of joining forces with a growing list of allies and partners to advance comprehensive efforts to prevent sexual abuse.
If you would like to partner with ATSA, please contact us at atsa@atsa.com.

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REVIEW OF THE FINAL REPORT: ENHANCING COURT AND PROBATION PRACTICES FOR CASES INVOLVING JUVENILES WHO COMMIT SEXUALLY ABUSIVE BEHAVIORS

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March 4, 2020

In June 2019 the National Center for State Courts and the Center for Sex Offender Management submitted a report to the Arizona Supreme Court's Juvenile Justice Services Division, providing an overview of existing practices and recommendations related to the management and treatment of juveniles adjudicated for sexual offenses (hereinafter referred to as the JSAB report). The following is a review of the degree to which the Guiding Tenets and Recommendations contained in that report align with the available research, current best practices, and professional standards in the field of assessment and treatment of juveniles who have engaged in sexually abusive behaviors (JSAB).

Taken as a whole, the JSAB report reflects the current best practice standards in the field. The recommendations are well supported by the available research. When research on an issue is not applicable or unavailable, the recommendations reflect the current best practice recommendations of the relevant professional organizations.

Historical Context

Studies of adult sexual offenders published before 1990 described the historical behavior of adults who were in treatment for criminal sexual activity. These studies often reported extraordinarily high rates of undetected "paraphilic acts" and victims (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987; Groth, Longo, & McFadin, 1982). Further, the assertion that sexual recidivism was typically "frightening and high" – up to 80%, (Freeman-Longo, & Wall, 1986), was widely accepted and incorporated into numerous policy positions and court decisions (See Ellman, & Ellman, 2915 for a detailed discussion). These studies often included a subgroup of juveniles and sex offender management policies and practices were often extended to JSAB's. The subgroup of juveniles in these studies were not independently analyzed to determine if the offense dynamics for adults applied to juveniles. Other studies

portrayed JSABs in terms commonly applied to adult offenders (Groth, 1977). These reports contributed to the assumption that JSABs were best understood as sex offenders who were young, rather than adolescents whose sexual misconduct was developmentally distinct from adult sexual offenders.

At the same time, multiple studies were raising questions as to the effectiveness of correctional rehabilitation in general (Lab & Whitehead, 1989; Martinson, 1974; Sechrest, White, & Brown, 1979) and sex offender specific treatment in particular (Seto & Barbaree, 1999). These forces contributed to a primary or exclusive emphasis on a "containment" approach to the management of sex offender risk. This approach is a philosophy that values public safety, victim protection, and reparation for victims as the paramount objectives of sex offender management and treatment (English 2004). The approach is grounded in an assumption that many sex offenders have a long history of assaulting many types of victims and will probably reoffend if not prevented from doing so. The approach stresses maximizing offender accountability and restricting the offender's access to potential victims and situations where additional offenses are possible (English, 1998). In line with those goals, polygraph testing, and treatment services generally, were used in part to obtain additional disclosures of victims or assaults in order to extend and individualize the supervision and restrictions placed on sex offenders (Ahlmeyer, Heil, McKee, & English, 2000; English, 1998).

Over recent decades the common belief that sex offense recidivism is "frightening and high" has not been supported by the available data. Although all sex offense recidivism is undetected at some point (until the perpetrator is caught), and presumably some portion of sexual recidivism remains undetected indefinitely, rates of detected sexual recidivism among adult sexual offenders have been modest (Langan, & Levin, 2002; Sample, & Brey, 2003). In

addition, mirroring the decline in violence of all types, sexual offense recidivism rates among adult prisoners released from prisons have declined 70% to 80% (Duwe, 2014; Helmus, 2009; Minnesota Department of Corrections 2007; Wisconsin Department of Corrections, 2015).

Recent studies have established that rates of detected sexual recidivism among JSABs have been quite low and declining. In a large meta-analysis involving 106 data sets and 33,783 JSABs Caldwell reported that the rate of detected sexual recidivism over an average 60-month follow-up was less than 5% (Caldwell, 2016). In addition, when older studies, which often contained large samples of individuals charged with homosexual acts, fornication, and promiscuity were eliminated, the rate of detected sexual recidivism showed a decline of 73% in recent decades to a current rate of 2.75%. Further, studies did not find higher recidivism rates with follow-up times exceeding 3 years. At the same time, these studies have consistently reported rates of detected general, non-sexual recidivism among JSABs that is 4 to 10 times greater than the sexual offense recidivism rate (Caldwell, 2016). In response to this emerging research, the field of assessment and treatment of JSABs has moved toward a more comprehensive assessment of the youth's psychosocial adjustment and treatment needs, and a more professional and empirically guided treatment approach. The recommendations in the JSAB report align with this trend toward more comprehensive and empirically guided assessment and treatment of JSABs.

JSAB Report Review

The JSAB report is organized into a series of Guiding Tenets and associated recommendations. Below these are addressed specifically, with more extensive discussion of the issues where the research is developing or issues are more complex.

GUIDING TENET 1: WELL-INFORMED STAKEHOLDERS ADVANCE WELL-INFORMED – AND MORE EFFECTIVE – SYSTEM RESPONSES.

This tenet and the associated recommendations align fully with the emerging best practices in the field. The Foundational Points of The Adolescent Practice Guidelines of the Association for the Treatment of Sexual Abusers (ATSA Practice Guidelines) note that emerging research has resulted in rapidly changing standards for assessment, management, and treatment of these youth. Section E items 2.0 through 2.7 of those guidelines emphasize the importance of well-trained practitioners that keep abreast of new developments in the field and avoid ineffective or potentially harmful approaches.

GUIDING TENET 2: DISPOSITION AND CASE MANAGEMENT DECISIONS ARE MORE EFFECTIVE WHEN DRIVEN BY ASSESSMENTS, RATHER THAN BEING OFFENSE DRIVEN.

This tenet accurately reflects the current best practices in the field and is reflected in the ATSA Practice Guidelines and in a recent monograph of the Association of Prosecuting Attorneys (Stern, 2018). Recommendation 10, involving the use of JSAB specific risk tools comports with common practice, however the reliability of these tools remains unestablished. For example, a recent National Institute of Justice solicitation for research proposals in this area noted "Although some empirical support for the predictive validity of the J-SOAP-II, the ERASOR, and the JSORRAT-II can be found in the literature, the instruments do not perform in a manner that suggests or shows their ability to predict juvenile sexual recidivism accurately" and concluded "There is a lack of consistent, independently corroborated empirical evidence concerning both the inter-rater reliability and predictive validity of juvenile risk assessments available for use at this time" (United States Department of Justice, 2013). These and other

sexual recidivism specific risk instruments have occasionally reported significant indices of accuracy in some studies. However, those results typically rely on adjusting the risk scores in such a way that very few JSABs fall into the high-risk group. The results typically produce very accurate predictions of non-recidivism in the low-risk youth, but poor accuracy in identifying youth who actually sexually reoffend. This has contributed to the standard of completing a more comprehensive assessment and is reflected in the remaining recommendations under this Tenet.

GUIDING TENET 3: THE USE OF POLYGRAPH EXAMINATIONS WITH JSAB IS BEST CONSIDERED THE EXCEPTION, NOT THE RULE.

This Tenet, and particularly Recommendation 18 under this Tenet, may be the most complex and controversial in the report. A more detailed discussion of the related issues follows.

Polygraph Uses

Appendix F of the JSAB report reviews the literature related to the lack of acceptance of the validity of the polygraph among the majority of the scientific community and the courts. In brief, courts have excluded polygraph results because they are deemed unreliable and researchers and professional organizations, with some exceptions (e.g. the American Polygraph Association), have opposed the use of the polygraph as unreliable. They address three issues involved with the use of the polygraph with JSABs: (a) whether the polygraph results in greater disclosure of misconduct; (b) whether the results of the polygraph are reliable; and (c) whether the use of the polygraph with JSABs can improve treatment outcomes.

Polygraph facilitated disclosures: With adults, the polygraph is commonly used as a way to promote sex offender's compliance with supervision conditions (Emerick & Dutton, 1993; English, Jones, Patrick, & Pasini-Hill, 2003; Grubin, Madsen, Parsons, Sosnowski, & Warberg,

2004). Although there is a compelling logic to this use, there is little empirical support that the polygraph increases openness about risk relevant behaviors. For example, in one of the few studies employing a comparison group, Grubin, et. al. (2004) studied sex offenders who were randomly assigned to a group who were told they would have a polygraph and a group who were told they would be visited by supervisory staff, but not polygraphed. The group that expected to be polygraphed did not report more high-risk behaviors than the group who expected only to be visited by supervisory staff.

Studies examining the use of the polygraph have demonstrated that disclosures of more victims and offenses can be obtained by use of the polygraph among adults (Ahlmeyer, Heil, McKee, & English, 2000; Wilcox & Sosnowski, 2005) and juvenile populations (Baker, Tabacoff, Tornusciolo, & Einsenstadt, 2001; Emerick, & Dutton, 1993; Stovering, Nelson, & Hart, 2013). However, these studies have several limitations. Although protocols have been developed and widely used, polygraph examinations are not standardized in a way that allows scientific validation. By necessity, the specific procedures must be tailored to the individual circumstances in a way that prevents controlled studies of the validity or reliability of the procedure (Ben-Shakhar, 2008). Furthermore, additional disclosures are nearly always assumed to be "truthful", an assumption that has not always held up to scrutiny.

Reliability issues: In addition to the limits on validity and reliability, research on the polygraph has documented several other concerns. Research studies have demonstrated that, in situations with a low base rate of deception, even studies that report high overall accuracy will often report as many individuals incorrectly categorized as "deceptive" as are correctly assigned that label. A review by the National Academy of Sciences noted that when base rates of deception are low, even a highly accurate test will produce as many false positives as true

positives (National Research Council, 2002). This issue is particularly problematic in applied settings because the base rate of deception in the group being examined is unknowable. However, even in research settings where the base rate is known, the rate of false positives can be quite high. For example, in a study of 263 polygraphs of 176 adult sex offenders in the community, Grubin and Madsen (2006) reported an overall accuracy of 85% for the polygraph, based on self-report. However, 51.5% of the results categorized as "deceptive" were actually truthful. In addition, 10% reported making false admissions during the polygraph examination out of a fear of being perceived as uncooperative, feeling pressured by the examiner, being confused, or wanting to demonstrate a commitment to therapy (Grubin & Madsen, 2006). Indeed, in some controlled studies, additional disclosures were limited to offenders who were involved in treatment programs that viewed additional disclosures as an indicator of treatment commitment or progress (Ahlmeyer, Heil, McKee, & English, 2000). Other studies have reported similar rates of false positive polygraph results (Grubin & Madsen, 2006; Ginton, Daie & Elaad, 1982; Kokish, Levenson & Blasingame, 2005; Lee, Lemaster, Hanlin, & Johnson, 2018; Patrick & Iacono, 1989, 1991).

Adolescents' Susceptibility to False Positives: A broad body of research has documented that juveniles are significantly more likely to provide false disclosures of misconduct than adults (Garratt, 2011; Gudjonsson, 2010; Kassin, Drizin, Grisso, Gudjonsson, Leo & Redlich, 2010; Redlich, 2007). Studies have found rates of false confessions of delinquent conduct among adolescents between 10 and 60 percent (Gudjonsson, Sigurdsson & Sigfusdottir, 2010; Gudjonsson, Sigurdsson, Sigfusdottir, Asgeirsdottir, Gonzalez & Young, 2016). Risk factors that predict higher rates of false disclosures of misconduct include having an ADHD, Conduct Disorder, Intellectual Disability, or other diagnosis of mental illness (Gudjonsson, Sigurdsson,

Sigfusdottir, Asgeirsdottir, Gonzalez & Young, 2016; Kassin, Redlich, Kulish & Steadman, 2011), being a victim and perpetrator of aggressive behavior (Gudjonsson, Sigurdsson & Sigfusdottir, 2010), being an older teen, or engaging in delinquent or antisocial behaviors (Drake, Gonzalez, Sigurdsson, Sigfusdottir & Gudjonsson, 2017; Gudjonsson, Sigurdsson, Sigfusdottir, Asgeirsdottir, Gonzalez & Young, 2016). In addition to more antisocial adolescents, those who tend to be more compliant with authority have been found to be at greater risk for false disclosures of misconduct (Gudjonsson, 2003). Thus, determining which adolescents are likely to provide a false disclosure is extremely difficult. In addition, some adolescents come to believe their false disclosures are actually accurate (Kassin, 1997; Wrightsman & Kassin, 1993) further complicating any effort to establish the appropriate scope and focus of treatment and supervision services.

Treatment Implications:

Regardless of the accuracy of the disclosure, the priority placed on full disclosure tends to focus treatment on issues of personal accountability, a full account of the individual's past misconduct, and the erosion of denial of misconduct. However, recent research has established that denial is not associated with future sexual misconduct in JSABs. Although categorical denial of involvement in the offense has been associated with more limited treatment progress in some programs for adult sex offenders that emphasize acceptance of responsibility for the offense (Levenson, & Macgowan, 2004), among adult sexual offenders, large meta-analytic studies have not found denial to be related to sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004; Kennedy & Grubin, 1992).

Among studies of JSABs, denial of the offense has been associated with lower rates of acceptance into treatment, of treatment compliance, and of treatment completion (Hunter, &

Figueredo, 1997; Hunter, & Figueredo, 1999) in treatment programs that emphasize full disclosure. However, at least seven studies have examined the association between denial and sexual recidivism – two of which found *lower* rates of sexual recidivism among JSABs that denied the offense (Kahn & Chambers, 1991; Redlack, 2003), and the remaining five found no association between denial and future sexual recidivism (Auslander, 1998; Caldwell, Dickenson, 2009; Caldwell, Ziemke, Vitacco, 2008; Schram, Milloy & Rowe, 1991; Spice, Vijoen, Latzman, Scalora, & Ullman, 2012). As a result, there is currently no empirical basis to consider denial to be a criminogenic factor that increases the risk of future sexual misconduct in JSABs.

In addition, studies that have looked at the number of offenses or victims in the history of JSABs have not found these issues to be a reliable measure of future sexual recidivism risk. In 11 studies that examined the number of victims, only two found that it predicted increased risk (Epperson, Ralston, Fowers, DeWitt, & Gore, 2006; Rassmussen, 1999), one found a relationship for youth with two, but not more, victims (Ralston, 2008), and eight found no increased risk (Caldwell, Ziemke, & Vitacco, 2008; Miner, 2002; Nisbett, Wilson, & Smallbone, 2004; Spice, Viljoen, Latzman, Scalora, & Ullman, 2013; van den Berg, Smid, Wever, van Beek, Janssen, Gijs, 2017; Waite, Keller, McGarvey, Wieckowski, Pinkerton, & Brown, 2005; Wolk, 2005; Worling, & Cruwen, 2000). Further, researchers have found that including offenses discovered through polygraph examinations, or undisclosed offenses, into risk measures with JSABs has not improved the accuracy of risk prediction measures (Gannon, Beech, & Ward, 2008; Ralston, Sarkar, Philipp, & Epperson, 2017). In this way, to the extent that a treatment program places an emphasis on full disclosure, they devote treatment resources to factors that are not risk-relevant.

Many authors point out the effect that polygraph examinations have on setting the framework of the treatment relationship. The best practice principles in the treatment of JSABs reflect a growing transition away from a primary or exclusive focus on sexual misconduct and onto a more comprehensive treatment of the general psychosocial adjustment of the youth. In this framework, denial or minimization of the youth's misconduct is viewed as a treatment responsivity issue, similar to other cognitive distortions, rather than a precondition for treatment progress. This transition reflects the recognition that studies of JSABs overwhelmingly show a much greater risk of non-sexual offending and other types of social maladjustment than continued sexual misconduct (Caldwell, 2016; Letourneau, Henggeler, Borduin, Schewe, McCart, Chapman, & Saldana, L., 2009; Letourneau, Harris, Shields, Walfield, Ruzicka, Buckman, et.al., 2018).

Treatment programs for JSABs are typically compulsory and the line between investigatory and police function roles of extracting information, holding the youth accountable and imposing aversive conditions, and the role of providing treatment can easily become blurred. Some authors have noted the ethical concerns that arise with compulsory polygraph testing of JSABs. For example, Chaffin (2011) has pointed out that "if a mental health treatment provider sets out to coerce incriminating confessions from a juvenile, intending that this will result in the juvenile's prosecution or sanctioning" this would violate the ethical principle of avoiding harm to the client. The point is supported by the fact that the United States is alone in using the polygraph in JSAB treatment programs, and in many countries polygraph examinations are not allowed for juveniles (Chaffin, 2011).

Professional Organization Positions

With no clear benefits and the potential for some harm to JSABs, and significant ethical concerns, several professional organizations and other western countries have taken a position opposing the use of the polygraph with juveniles (American Academy of Child and Adolescent Psychiatry, 2014; American Psychological Association, 2004; Association for the Treatment of Sexual Abusers, 2017; Stern, 2018; United Kingdom Offender Management Act of 2007).

Perhaps no organization has considered this issue as extensively as the Juvenile Practice Committee of the Association for the Treatment of Sexual Abusers. The Committee took up the issue in 2016 and debated the issue for most of the year, eventually recommending to the Governing Board of ATSA that the organization take the position recommending against the use of the polygraph with adolescents. The issue was re-visited in late 2017 and after further discussion the position was confirmed.

Shortly after the publication of ATSA's position, the American Association of Prosecuting Attorneys issued a monograph addressing a host of issues in the prosecution of sex crimes committed by juveniles. After a thorough review of the literature the monograph took the position; "The use of the polygraph and the plethysmography have no place in the assessment or treatment of adolescents alleged to have engaged in sexually abusive behavior. Prosecutors must be insistent in relying only on reliable, valuable and ethically obtained data. Polygraphy and plethysmography use with juveniles fail to meet that threshold" (Stern, 2018).

In brief, the information contained in Appendix F of the JSAB report is an accurate summary of the available research. Further, the recommendations under Guiding Tenet 3 of the JSAB report regarding the use of polygraph testing with JSABs are in line with the current best practices and the recommendations of multiple professional organizations.

The above notwithstanding, many jurisdictions in the United States continue to rely on polygraph examinations. The Recommendations 19 through 24 under this Tenet provide guidelines to minimize the potential for harm or misuse of the polygraph with JSABs for jurisdictions that continue this practice. These guidelines are generally accepted in the field and comport with the research evidence on which populations are most susceptible to harm, and what uses of the polygraph are most apt to cause harm.

GUIDING TENET 4: INDIVIDUALIZED, EVIDENCE-INFORMED TREATMENT INTERVENTIONS PROMOTE SUCCESSFUL OUTCOMES WITH JSAB.

This Tenet reflects the best practices in the field at this time. Items 9.5 to 9.30 of the ATSA Practice Guidelines emphasize the use of treatment programming and services that are evidence-informed, and practitioners that stay up-to-date on the emerging research into the effectiveness of treatment approaches.

This emerging research has contributed to an emphasis on comprehensive, multi-dimensional and individualized treatment services for JSABs as an effective way to reduce sexual violence in the community. Of course, the effectiveness of treatment programs will vary from program to program and youth to youth. However, it is now widely accepted that the relationship with the youth being treated is an important variable in producing positive results (Chaffin, 2011; Prescott, 2012) as are programs that rely on Cognitive Behavioral Treatment and psycho-educational programs delivered by highly qualified clinicians (Gannon, Olver, Mallion, & James, 2019). The consensus in the field is that these services should be focused on demonstrably risk-relevant areas. The ATSA Guidelines (Section F, Treatment Interventions) provides a detailed discussion of the importance of providing treatment that considers the whole youth and their social context. Recommendation 28 under this Tenet addresses the demonstrated

effectiveness of MST/MST-PSB programs and recommends that JJSD explore the reasons that MST/MST-PSB are substantially underutilized. This aligns with the available research that has demonstrated that the treatment approaches with the most empirically supported evidence of effectiveness utilize the MST/MST-PSB approach, which focuses on family and community integration and general psychosocial functioning and places relatively limited emphasis on full disclosure of prior misconduct (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin, Schaeffer, & Heiblum, 2009; Henggeler, Letourneau, Chapman, Borduin, Schewe, & McCart, 2009; Letourneau, Henggeler, Borduin, Schewe, McCart, & Chapman, 2009).

GUIDING TENET 5: PROBATION PRACTICES WITH JSAB SHOULD BE EVIDENCE-BASED AND PROMOTE POSITIVE YOUTH DEVELOPMENT.

This Tenet reflects the best practices and treatment standards in the field that are grounded in a recognition that JSABs predominantly engage in sexual misconduct during a specific developmental stage of their lives. The recognition of this fact is incorporated into several sections of the ATSA Guidelines, particularly sections 9.5 to 9.10, dealing with providing treatment for the whole youth in a broad social-ecological approach.

Conclusion

The field of assessment and treatment of juveniles involved in sexual misconduct has been evolving rapidly in recent decades. Although there are some areas involving complex or controversial issues, the JSAB report is an accurate reflection of the current state of the art, based on the established empirical research and accepted best practice and professional standards in the field.

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AOC Protocol for submitting Request for Exceptional Circumstance Polygraph

Effective Date: January 1, 2021

One review and one request per polygraph.

Request for Polygraph under Exceptional Circumstances is to be made by the **Staffing Team**.

The Staffing Team consists of: Treatment staff (therapist, psychiatrist, etc.), probation officer(s), parent / guardian, guardian ad litem (GAL) or other invested stakeholders.

Prior to any consideration of Polygraph, the Staffing Team must ensure the following:

1. The juvenile has been in treatment long enough to have the opportunity for establishment of rapport and has had reasonable time to become engaged in the treatment process; there has been sufficient time for the therapist to employ alternate methods and skills in the treatment process.
2. Staffing team discusses progress and barriers to progress in treatment;
3. Staffing team discusses methods & therapeutic interventions that have already been tried to address the barrier(s) to progress in treatment.
4. If Staffing team determines that there are no other alternatives, discussion ensues as to the rationale for requesting an exceptional polygraph request.
5. **Rationale for an Exceptional Polygraph** request. The Staffing team (all stakeholders) shall determine the following (to be included in the written request to the Judge):
    - What is the specific rationale based on individual risk and need (i.e. cases with high or difficult to manage risk posing barriers to treatment)
    - What information is being sought by the polygraph?
    - How will this information inform treatment?
    - Are there any alternate methods which can be utilized to obtain the information being sought. Identify which methods were utilized, why those methods did not work or which methods should not be used as a viable option and the rationale.
    - What current behavior(s), risk factors, or treatment need(s) is the Staffing Team concerned with and how will this be addressed by polygraph testing?
6. Staffing team shall review all the **Suitability / Exclusionary factors** for a polygraph request (see criteria below)
7. If consensus exists within the Staffing team after completing the process steps above, they shall gather all required documents for submission with the request and write the rationale for a formal request to the judicial officer for approval of an exceptional polygraph.
8. Staffing team shall submit all documents to the Probation Officer. The rationale must answer the questions in #5 above; must include an affirmation that all **Suitability / Exclusionary** criteria are met; and must confirm that all stakeholders are in consensus as to the request for polygraph

9. The Probation Officer shall submit the documents and formal request to the judge for review.
10. The judge shall review and make final determination about whether to approve or disapprove the request for **one (1)** polygraph.

Suitability Criteria/Exclusionary Factors for Polygraph Testing (*Source: American Polygraph Association / PSCOT Model Policy 2018):

Suitability Criteria: The staffing team shall review the following **suitability criteria** when considering a referral for polygraph examination: **This needs to be a clinical assessment decision.**

1. Chronological age of 14 or older and a minimum functional age-equivalency of 12 years. Standardized psychometric testing shall be employed when there is doubt about a juvenile's level of functioning.
2. Capacity for abstract thinking
3. Capacity for insight their own and other's motivation
4. Capacity to understand right from wrong
5. Ability to tell truth from lies
6. Ability to anticipate rewards and consequences for behavior
7. Consistent orientation to date, time, place
8. Adequate intellectual/adaptive and executive functioning
9. Does not meet exclusionary factors

Exclusionary Factors: The staffing team shall review the following **exclusionary factors** and not refer juveniles for polygraph testing when any of the exclusionary factors are present:

1. Diagnosis of psychotic condition per the current version of the DSM
2. Lack of contact with reality
3. DSM severity specifier of "severe" for any diagnosis
4. Presence of acute pain or illness
5. Presence of acute distress
6. Recent medication changes that negatively impact functioning
7. Mean Age Equivalency (MAE) or Standard Age Score (SAS) is below 12 years (per standardized psychometric testing)
8. Clear indicators exist that results would be invalid

In addition, when submitting the **Request for Polygraph Examination** to the judicial officer, the Staffing Team shall additionally affirm the following:

1. That the juvenile has been adjudicated delinquent per ARS 8-350.01
2. That the juvenile has been currently involved in JSAB counseling services long enough to determine that a significant barrier exists precluding the juvenile from moving forward with treatment processes.
3. That the services provided up to this time have focused on reducing risk factors and enhancing protective factors in the juvenile's ecology; however, barrier(s) have presented in treatment that the Staffing Team have identified as the rationale for seeking the polygraph.
4. That the polygraph will be used for JSAB treatment purposes only.
5. That there is consensus in the Staffing Team, including the Parent / guardian, that a polygraph is needed and will support the juvenile's treatment progress.
6. The request includes a written statement from the treatment provider or a medical doctor that the juvenile is medically, psychiatrically and developmentally able to participate in the polygraph process (see above for criteria).

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

GUIDING PRINCIPLES FOR MARYLAND BY MR. BEN GALARANEAU

Juvenile sex offender treatment in Maryland focuses on rehabilitation, accountability, and community safety through individualized risk assessment,, often employing cognitive-behavioral or family-based therapies like Multisystemic Therapy (MST). Programs commonly involve mandated, specialized counseling and, in some cases, supervision tools like polygraphs to address recidivism.

Guiding Principles and Treatment Approaches

- **Comprehensive Assessment:** Juveniles undergo evaluations for risk and needs, leading to individualized treatment plans that include, but are not limited to, individual and group therapy.
- **Family-Focused Care:** Treatment often centers on family systems, engaging parents and siblings to address behavioral, cognitive, and emotional factors.
- Multisystemic Therapy (MST)**:** This family-based intervention is used to address multiple factors associated with delinquent behavior, proving effective for rehabilitation.
- **Collaborative Management:** In Maryland, Collaborative Offender Management Enforcement Treatment (COMET) models are used to monitor compliance through specialized probation, which may include polygraph tests.
- **Specialized Training:** Treatment providers for individuals petitioning for discharge are often required to be approved by the Department of Public Safety and Correctional Services.

Key Management Strategies

- **Individualized Treatment:** Conditions are tailored to the juvenile, often involving group therapy co-facilitated by therapists and probation officers.
- **Risk Mitigation:** The goal is to reduce future offenses through clinical treatment, focusing on cognitive understanding of the offense and relapse prevention.
- **Legal Protections/Registry:** Maryland Law has specific, often contested, procedures for juvenile sex offender registration, with discussions focused on balancing rehabilitation with public safety, including potential legislation to manage how juvenile offenders return to school.

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

DOCUMENTS PROVIDED

BY

MR. BEN GALARANEAU

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KENTUCKY

Standard Operating Procedures Manual for the Treatment of Declared Juvenile Sexual Offenders

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11/01/2019

Kentucky Department of Juvenile Justice

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Applicability Statement

This Standard Operating Procedures (SOP) Manual shall only apply to those youth who are declared Juvenile Sexual Offenders (JSOs) per KRS 635.510 except as provided in Section II regarding post adjudication assessments.

Section I - Confidentiality

A. Communications with JSOs shall be confidential as set forth in KRS 635.527 (Communications made in the application for or in the course of a child sexual offender's diagnosis and treatment in the program, between a sexual offender or member of the sexual offender's family and any employee of the department who is assigned to work in the program, or any approved provider as defined in KRS 17.500, shall be privileged from disclosure in any civil or criminal proceeding, other than proceedings to determine the sentence, unless the sexual offender consents in writing to the disclosure or the communication is related to an ongoing criminal investigation. The privilege created by this section shall not extend to disclosures made for the purpose of determining whether the sexual offender should continue to participate in the program. The provisions of KRS 620.030 shall not apply to a communication made, received, or overheard if the communication is made pursuant to this section.).

B. The Juvenile Service Worker (JSW) or treatment provider shall notify the youth in writing of their rights regarding confidentiality pursuant to KRS 635.527 (The child sexual offender shall be informed in writing of the limits of the privilege created by this section.). The Department of Juvenile Justice (DJJ) shall afford the youth the opportunity to speak with their attorney prior to signing any waiver of confidentiality as provided by KRS 635.527. A waiver shall not be accepted unless the waiver is signed by both the youth and their attorney.

Section II – Sex Offender Specific Assessment

A. All youth eligible to be declared a JSO under KRS 635.505(2)(a)–(g) shall be referred for a juvenile sexual offender assessment by the JSW to the Regional Psychologist.

B. At the time of adjudication on an offense under KRS 635.505(2), the JSW shall request a separate disposition. The JSW shall request that the separate disposition date be set at least six (6) weeks after the date of the adjudication. The JSW shall additionally request a court order for the completion of a juvenile sexual offender assessment. The JSW shall make the referral for assessment to the Regional Psychologist within three (3) business days following adjudication.

C. The JSW shall, at the time of referral, provide or request through means of release of information, the following information, as available, to the mental health assessor:
   1. Police interview transcripts or auditory and video recordings;
   2. Victim impact statement;
   3. Legal history including other charges and dispositions;
   4. Current petition and all other related court calendars and docket sheets, and any audio or video of an adjudication hearing or trial;
   5. Educational information including attendance, special education identification, and copy of last psychological or psycho-educational evaluation, as applicable;
   6. Previous outpatient counseling and evaluations, as applicable;
   7. Previous psychiatric hospitalizations and evaluations, as applicable; and
   8. Child protective services history, as applicable.

D. The sex offender specific assessment shall be completed by the Mental Health Branch with the participation of the youth and the parent or caregiver.

E. The sex offender specific assessment shall identify the source of all outside information. The assessment shall take into account all available information and not rely solely on one (1) source. The assessment shall contain all the components outlined in KRS 635.505(3) with required content to include:
   1. Identifying information:
      a. Name;
      b. Age; and
      c. Date of Birth;
   2. Dates of evaluation;
   3. Date of report;
   4. Assessor's name and credentials;
   5. Reason for referral;
   6. Data sources from Section II. C., which were relied upon;
   7. Social Development and History;
   8. Substance Use History;
   9. Medical History, including any medical diagnosis of a disability;

10. Educational History, including an estimate of intellectual functioning, if available. If the Educational History indicates that the youth has an Intelligence Quotient (IQ) of seventy (70) or below this shall be noted in the assessment (KRS 635.505 and 635.510);
11. Legal History:
    a. Current and past offenses; and
    b. Number of victims, ages, and relationships to offender;
12. Family History, including ecological factors;
13. Sexual History, including the following information, if applicable:
    a. Sexual knowledge;
    b. Sexual abuse victimization;
    c. History of sexually abusive behavior or sexually inappropriate behaviors;
    d. Dating and sexual relationships abuse issues;
    e. History of masturbation;
    f. History of deviant sexual interest, fantasy, arousal, or pornography; and
    g. History of sexual interest, fantasy, arousal, or sexual activity with animals;
14. The current functioning and behavior of the youth for the past six (6) months including the observations of the parent or caregiver and the self-report of the youth;
15. Other mental health assessments or treatment information, which may have been provided to the assessor;
16. Strengths, motivation, and prosocial living;
17. Protective factors;
18. Information regarding the risk for reoffending utilizing available risk assessment tools as well as clinical judgment by the mental health assessor, including a specific statement for each assessment tool used related to validity, reliability, and limitations of the instrument;
19. Summary section, which shall summarize all information included in the report (Section II. E. 1-18), including information regarding the youth's risk of reoffending; and
20. Recommendations section, which shall:
    a. Focus on:
        i. The individual treatment needs of the youth to address the identified sexual behavior problems, if any;
        ii. A recommendation of whether or not the youth should be declared a juvenile sex offender;
        iii. A recommendation for the most appropriate treatment modality; and
        iv. The least restrictive environment in which that treatment can be provided to the youth; and
    b. Not address the risk of reoffending.

F. The youth and parent or caregiver shall be given written information regarding the Health Information Portability and Accountability Act of 1996 (HIPAA), by the

JSW and the Mental Health Branch assessor which shall be acknowledged in writing by the youth and parent or caregiver. If the youth, parent or caregiver refuses to sign the acknowledgment this shall be documented in the youth's individual client record (ICR). The HIPAA and acknowledgement shall be mailed to the parent or caregiver in situations when the parent or caregiver is not available, with a request that the acknowledgement be signed and returned.

G. The youth shall not be required to describe or discuss his committing offense and the assessor shall not use the youth's refusal as an indicator of risk.

H. The completed sex offender specific assessment shall be forwarded by the mental health assessor to the Regional Psychologist for review and approval within seven (7) business days prior to the disposition date. If the Regional Psychologist completes the assessment it shall be reviewed and approved by the next line supervisor.

I. The sex offender specific assessment shall be completed, reviewed, and approved by the Regional Psychologist five (5) business days prior to the disposition date. The sex offender specific assessment shall be provided to the JSW four (4) business days prior to the disposition date. The JSW shall submit this report along with the Predisposition Investigation (PDI) to the youth's attorney, the prosecutor, and the court three (3) business days prior to disposition per KRS 610.100.

J. For youth who are in Circuit Court and a Presentence Investigation (PSI) report is ordered, the sex offender specific assessment shall be completed, reviewed, and approved by the Regional Psychologist ten (10) business days prior to the sentencing date. The sex offender specific assessment shall be provided to the JSW seven (7) business days prior to the sentencing date. The JSW shall submit this report along with the PSI to the youth's attorney, the prosecutor, and the court five (5) business days prior to sentencing.

K. If requested by the parent or caregiver, a meeting shall be held by the mental health assessor to discuss a summary of the results and the recommendations, based on the evaluation. A copy of the summary and the recommendations may be provided to the youth and parent or caregiver if requested. Reference DJJPP Chapter 1 (Records Request).

L. If at disposition the court does not declare the youth a JSO no further action shall be taken in this manual.

Section III - Juvenile Sexual Offender Specific Treatment Components

A. The Sexual Offender Treatment Program (SOTP) is a continuum of treatment, which may include services provided in the community, in a residential setting, or in a combination thereof.

B. Unless otherwise ordered by the court, sex offender treatment shall be continuously provided while a case is on appeal with the exception of describing or admitting to the committing offense. If a youth's case is on appeal, the youth may complete their treatment plan and be discharged from residential placement.

C. The Juvenile Sexual Offender Treatment Components shall:
   1. Incorporate social learning, cognitive-behavioral, and behavioral skills-based approaches;
   2. Be the holistic treatment of the youth, taking into consideration the diverse and socio-ecological, dynamic nature of adolescent development;
   3. Be assessment-driven, including determination of criminogenic needs, protective factors and normative or atypical sexual behaviors with identification of contributing factors and intervention needs;
   4. Encompass efforts by the treatment provider to include caregivers and other positive supports to foster youth and family engagement and to enhance treatment motivation;
   5. Incorporate guiding principles of healthy social, psychological and cognitive development to enhance prosocial, healthy relationships and healthy lives;
   6. Focus on research supported dynamic factors related to sexual recidivism;
   7. Focus on research supported dynamic factors related to nonsexual recidivism criminogenic needs, if indicated;
   8. Facilitate the development of positive therapeutic relationships to enhance treatment response and personal responsibility; and
   9. Focus on treatment targets commonly associated with sexual recidivism, as deemed relevant for an individual youth or his or her family.

D. Relevant treatment targets specific to sexual recidivism to be evaluated for inclusion on a youth's treatment plan shall include:
   1. Social Isolation, Low Social Competence;
   2. Attitudes Supportive of Abusive Behavior;
   3. Parent-Adolescent Relationships, including healthy family living plan and enhancing relationships and caregiver capacity to supervise, monitor, and intervene;
   4. General Self-Regulation deficits;
   5. Healthy Sexuality including sex education, atypical sexual interests, sexual drive and preoccupation, if present, and sexual self-regulation;
   6. Social-ecological factors, including family, social and community supports;
   7. Nonsexual delinquency, including antisocial orientation, beliefs, attitudes and peer associations, if relevant; and
   8. Accountability and responsibility for sexual offending, including but not limited to healthy self-regulation planning and victim recognition and awareness.
   9. For youth not admitting to the sexual offending behavior the treatment provider shall consult with the treatment team, including the regional psychologist if applicable, for possible adjustments to the treatment plan to allow for progression in treatment.

E. Additional areas of consideration for adjunct treatment targets may include:

1. Community Law Education;
2. School Behavior Issues;
3. Personal Victimization and Other Trauma History;
4. General Mental Health Issues;
5. Substance Abuse Treatment; or
6. Situational, Environmental, Family, or System Issues.

F. A youth declared a JSO shall be committed to the custody of DJJ pursuant to KRS 635.515 and shall receive sexual offender treatment for up to three (3) years. The time period of sexual offender treatment may be extended for one (1) additional year by the sentencing court upon motion of DJJ. The JSO shall not remain in the care of DJJ after the age of twenty-one (21) years.

G. Declared Juvenile Sexual Offender Tracking

1. DJJ shall maintain a Juvenile Sexual Offender Tracking System (JSOTS).
2. For a youth to be entered on JSOTS, the JSW shall complete a Part I Initial Tracking form and submit the form to the JSOTS Administrator, located in the DJJ Central Office, within thirty (30) days of disposition.
3. The JSOTS Administrator shall:
   a. Enter the data from the Part I form into the tracking database;
   b. Generate the Part II tracking form; and
   c. Send the Part II tracking form to the JSW.
4. The JSW shall complete the Part II form and return it to the JSOTS Administrator within ten (10) business days.
5. Per KRS 635.515(5), DJJ is required to send the committing judge a written report every sixty (60) days from the date of disposition. The JSW shall complete the sixty (60) day report to the court as described in Sections III G and H.
6. The JSW shall provide the JSOTS Administrator with a copy of each sixty (60) day report that is sent to the court.
7. The JSOTS Administrator shall send a monthly report showing DJJ's compliance with KRS 635.515 to each Community Regional Manager, Juvenile Services District Supervisor (JSDS), Facilities Regional Administrator (FRA), and Superintendent on the tenth (10^{th}) of each month.
8. A youth shall be removed from JSOTS under one (1) of the following conditions for which the JSW shall provide supporting documentation to the JSOTS Administrator:
   a. The youth has received the maximum years of treatment per KRS 635.515(1);
   b. The youth was sentenced as a Youthful Offender (YO) and has been transferred to the Department of Corrections (DOC);
   c. The youth has reached age twenty-one (21);
   d. The youth has completed the treatment program prior to the statutory maximum and was released from commitment upon recommendation by DJJ; or

e. The youth's commitment has been terminated or suspended by the court.

H. Treatment of Declared Juvenile Sexual Offenders with Community Placement

1. If a youth is in a community placement, the JSW assigned the case management responsibilities shall request treatment from the Regional Psychologist or designee within two (2) business days of disposition or upon return from an out-of-home placement. This request is not required when the youth is seeing a private provider prior to disposition and the parent or caregiver wants the youth to continue seeing the private provider. The provider shall be approved by DJJ. Reference DJJPP Chapter 8 (Private Provider Application, Approval, and Renewal Process for Juvenile Sexual Offender Treatment or Assessor Status).
2. For youth whose treatment is provided by a DJJ approved professional, the JSW shall provide the private professional with the DJJ juvenile sexual offender treatment components, ensure the private professional agrees to address the mandatory components within the youth's treatment, and inform the private professional of their responsibility to provide a treatment agreement to the youth per KRS 635.515 (3). Reference DJJPP Chapter 8 (Private Provider Application, Approval, and Renewal Process for Juvenile Sexual Offender Treatment or Assessor Status).
3. The Regional Psychologist, or designee, shall assign the treatment provider within two (2) business days of receipt of the request. The Mental Health Branch staff shall contact the youth and parent or caregiver to schedule an initial appointment within five (5) business days of receipt of referral from the Regional Psychologist.
4. The parent or caregiver shall be provided orientation to treatment by the Mental Health Branch staff at the first meeting. The Mental Health Branch staff shall explain treatment expectations for the youth and parent or caregiver.
5. The provider of the sexual offender specific treatment shall develop an individual treatment plan (ITP) with the youth, parent or caregiver, and JSW to outline the expectations and provision of the sexual offender treatment. Reference DJJPP Chapter 3 (Individual Treatment Planning and Aftercare Planning).
6. The Mental Health Branch staff shall complete a treatment agreement on all youth who are on conditions of supervised placement that details the responsibilities of the declared juvenile sexual offender, the parent or caregiver, and the program. These responsibilities shall include attendance, participation in education, participation in planning and completion of treatment goals, curfew, home visits, participation in parenting groups and family counseling, continued contact with the program, schools, and court, insurance of legal rights, and discharge criteria as required in KRS 635.515(3).
7. The Mental Health Branch staff shall review the acknowledgement of HIPAA privacy practices and obtain all necessary signatures.
8. The Mental Health Branch staff shall inform the youth and parent or caregiver in writing of the confidentiality rights as established in KRS 635.527 and shall inform the youth and parent or caregiver of the role of the treatment team.

9. Releases of information shall be obtained, as needed, from the youth and parent or caregiver to share appropriate information with collateral agencies, to include school systems and other individuals or agencies providing services.
10. Treatment shall be provided to address the needs and risks of the juvenile. Reference DJJPP Chapter 6 (Case Planning and Participation in Treatment Planning) and (Community Mental Health Operations).
11. The mental health clinician shall address the sexual offending behavior in the ITP. All treatment plans shall be completed in accordance with DJJ Policy.
12. The youth and parent or caregiver shall be required to cooperate with the sexual offender treatment provider pursuant to KRS 610.160.
13. Reviews of the youth's progress shall be conducted every sixty (60) days regardless of the youth's placement as required by KRS 635.515 and a court report generated. This sixty (60) day court report shall include information about treatment received by the juvenile sex offender and parent or caregiver, assessment of the offender's current condition, and recommendations of the staff. The JSW shall prepare the report for the court incorporating the evaluation of how the youth and parent or caregiver are responding to treatment.
14. The treatment provider shall provide a verbal or written summary of treatment and progress every sixty (60) days from the date of initiation of treatment to the JSW. Coordination shall occur between the treatment provider and the JSW to ensure that the summary of treatment and progress is received by the JSW prior to submission of the sixty (60) day court report.
15. The JSW and DJJ shall document the youth and parent or caregiver's treatment progress in the youth's ICR.

I. Treatment of Declared Juvenile Sexual Offenders in Out-of-Home Placement

1. If a youth is in an out-of-home placement, the treatment team shall address the sexual offending behavior in the ITP. All treatment plans shall be completed in accordance with DJJ Policy.
2. Youth placed in foster care shall be provided juvenile sexual offender treatment by DJJ Mental Health Branch staff or by a DJJ approved private provider, as available. The JSW assigned the case management responsibilities shall initiate the referral for treatment to the Regional Psychologist or DJJ approved private provider, as available.
3. The youth and parent or caregiver shall cooperate with the sexual offender treatment provider pursuant to KRS 610.160.
4. Releases of information shall be obtained, as needed, from the youth and parent or caregiver to share appropriate information with collateral agencies, to include school systems and other individuals or agencies providing services.
5. The treatment provider shall review the acknowledgement of HIPAA privacy practices and obtain all necessary signatures.
6. The treatment provider shall inform the youth and parent or caregiver in writing of the confidentiality rights as established in KRS 635.527 and shall inform the youth and parent or caregiver of the role of the treatment team.

7. Treatment shall be provided to address the needs and risks of the juvenile. Reference DJJPP Chapter 3 (Individual Treatment Plan and Aftercare Plan).
8. Reviews of the youth's progress shall be conducted every sixty (60) days regardless of the youth's placement as required by KRS 635.515 and a court report generated. This sixty (60) day court report shall include information about treatment received by the juvenile sex offender and parent or caregiver, assessment of the offender's current condition, and recommendations of the staff. The JSW shall prepare the report for the court incorporating the evaluation of how the youth and parent or caregiver are responding to treatment.
9. The treatment provider shall provide a verbal or written summary of treatment and progress every sixty (60) days from the date of initiation of treatment to the JSW. Coordination shall occur between the treatment provider and the JSW to ensure that the summary of treatment and progress is received by the JSW prior to submission of the sixty (60) day court report.
10. The JSW and DJJ treatment provider shall document the youth and parent or caregiver's treatment progress in the youth's ICR.
11. For youth in out-of-home placement receiving treatment from a private treatment provider, the JSW shall schedule and document the review as outlined in policy.

J. Auditing of cases shall be completed in compliance DJJPP Chapter 3 (Counseling Services) and DJJ Chapter 6 (Community Mental Health Operations).

Section IV – Victim Reunification and Family Reintegration

Applicability Statement: This Section IV shall be applicable to circumstances in which the victim is a member of the JSO's family. This Section IV additionally shall apply when the victim plans to live in the same home as the JSO or the same home that the JSO is expected to live in upon release from a residential placement.

A. Victim safety shall be the primary consideration in any plan for contact or reunification. All contact shall be victim centered and based on victim need. Reunification with the victim or family reintegration shall not indicate completion of treatment.

B. Victim reunification shall only be considered if the JSO, parent or caregiver, and victim are ready for the process. An assessment of readiness by both the victim and JSO's treatment providers' shall guide this process. For youth in residential placement, efforts shall be made to begin this process prior to discharge. However, victim's lack or readiness shall not impede the offender's return to the community setting.

C. The clarification process begins with the JSO in treatment for abusive behaviors, progresses to an apology letter, and if appropriate, may move towards a highly structured and facilitated clarification session.

D. A comprehensive healthy family living plan is one that identifies the strengths of the family as well as the risk factors, patterns, and warning signs of abuse and offers concrete boundaries for the family to maintain for everyone's safety.

E. Even after family reintegration has begun, situations may arise in which there is a decision to terminate the process.

F. Victim reunification may be addressed in aftercare planning and may be revised as appropriate through the course of treatment.

G. The treatment team shall:
   1. Collaborate with the victim's therapist or advocate, guardian, custodial parent, foster parent, or guardian ad litem, in making decisions regarding communication, visits, and reunification counseling sessions;
   2. Support the victim's wishes regarding contact with the youth to the extent that it is consistent with the victim's safety and well-being; and
   3. Complete the healthy family living plan and youth self-regulation plan prior to the youth's reintegration into the home.

H. If the treatment team recommends that the youth should have contact with the victim and there is an existing court order to have no contact with the victim, the JSW, after collaborating with the treatment team, shall schedule a court review to present a progress update on youth's treatment to request that the court order be modified or rescinded to allow contact.

I. DJJPP Chapter 3 (Authorized Leave: Day Releases and Furloughs; Supervised Off-grounds Activities) shall be followed with regard to furloughs for a JSO, including the requirement that a JSO shall only be approved for release to the JSO's parent or caregiver for a day release, furlough, or emergency leave by the Treatment Team with notification to the Regional Director. Furlough time for a

declared JSO, prior to program completion, shall be considered on a case by case basis and shall not exceed ten (10) days.

Section V –Procedures for Reassessment and Criteria for Termination of Sex Offender Treatment

A. Release from sex offender treatment shall not equate to release from commitment. All youth shall be subject to department policy and procedure regarding release from commitment.

B. The criterion for termination of sex offender treatment shall be directly related to the completion of all of the sex offender specific treatment goals on the youth's ITP.

C. In circumstances where the youth is receiving sex offender treatment in a residential facility, completion of the residential component may not equate to completion of the sex offender treatment program.

D. Procedures for Reassessment:

1. The treatment team shall meet and recommend termination of treatment for youth who have successfully completed the sex offender treatment goals on their ITP. In making this determination, the treatment team shall:
    a. Consider all sources of collateral information; and
    b. Assess and document evidence that the goals on the treatment plan have been met.
2. For youth who are receiving sex offender treatment in the community and are nearing completion of sex offender treatment, a juvenile sexual offender reassessment shall be completed. If the sex offender treatment is being provided by a DJJ mental health staff the reassessment shall be completed by the mental health staff and approved by the Regional Psychologist. If the reassessment is completed by the Regional Psychologist it shall be reviewed and approved by the next line supervisor. If sex offender treatment is provided by an approved private provider, the private provider shall complete a juvenile sexual offender reassessment or an equivalent treatment summary noting the youth's progress in treatment, reasons for completing treatment, and current risk level to reoffend.
3. Reassessment of Youth in a Youth Development Center
    a. A reassessment shall be required for youth who are receiving sex offender treatment in a youth development center (YDC) under one of the following circumstances:
        i. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment;
        ii. The youth has completed sex offender treatment and will not be receiving further treatment in the community; or
        iii. The youth is being placed on furlough. A reassessment shall not be required prior to furloughs where the youth is expected to return to the facility after the furlough. Reference DJJPP Chapter 3 (Authorized Leave: Day Release and Furloughs; Supervised Off-grounds Activities) and DJJPP Chapter 6 (Authorized Leave for Public Offenders, Juvenile Sexual Offenders, and Youthful Offenders in Placement).

b. The juvenile sexual offender reassessment shall be completed by the treatment director or counselor. If the reassessment is completed by the counselor, the treatment director shall review and approve. If the reassessment is completed by the Treatment Director it shall be reviewed by the Regional Psychologist or a board approved clinical supervisor.

4. Reassessment of Youth in a Group Home
   a. A reassessment shall be required for youth who are receiving sex offender treatment in a group home under one the following circumstances:
      i. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment;
      ii. The youth has completed sex offender treatment and will not be receiving further treatment in the community; or
      iii. The youth is being placed on furlough. A reassessment shall not be required prior to furloughs where the youth is expected to return to the facility after the furlough. Reference DJJPP Chapter 3 (Authorized Leave: Day Release and Furloughs; Supervised Off-grounds Activities) and DJJPP Chapter 6 (Authorized Leave for Public Offenders, Juvenile Sexual Offenders, and Youthful Offenders in Placement).
   b. The juvenile sexual offender reassessment shall be completed by the counselor or mental health staff and shall be reviewed and approved by the Regional Psychologist.
5. The JSW shall request a reassessment or discharge summary for youth who are receiving sex offender treatment in a private childcare, therapeutic foster care, or a hospital setting under one the following circumstances:
   a. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment; or
   b. The youth has completed sex offender treatment and will not be receiving further treatment in the community.
6. Reassessments for YOs who are declared sex offenders shall not be required prior to the youth's final sentencing hearing unless requested by the court.

E. The reassessment shall contain updates from the initial risk assessment of the following required content:
   1. Identifying Information;
   2. Assessor;
   3. Reason for Referral;
   4. Data Sources;
   5. Assessment Interview and Behavior Observation;
   6. Legal History;
   7. Family History;
   8. Social History and Peer Relations;
   9. Recent Behaviors;
   10. Education and Vocation;
   11. Substance Use and Treatment History;
   12. Medical and Mental Health History;

13. Treatment Progress;
14. Risk Assessment Results; and
15. Summary and Recommendations.

F. All juvenile sexual offender reassessments shall be sent to the youth's JSW.

G. Process for Termination of Juvenile Sexual Offender Treatment

1. The JSW shall complete the Request to Release from Sex Offender Treatment on all declared JSO's, regardless of placement, and submit through the chain of command. A copy of the juvenile sexual offender reassessment or private provider treatment summary shall be attached.
2. The Division Director of Community and Mental Health Services shall give final approval to release a declared JSO from sex offender treatment, regardless of placement.
3. Upon receiving final approval, the JSW shall request the committing court to re-docket the youth's case for review per KRS 635.515(7). The court review shall be requested sixty (60) days prior to the recommended date of release from treatment.
4. Release from sex offender treatment shall not equate to release from commitment. All youth shall be subject to department policy and procedure regarding release from commitment.
5. Termination without completion of the sex offender treatment shall not be determined by the treatment team. When the treatment team has determined that a youth is not making progress and will not benefit from continued sex offender treatment, a report shall be forwarded through the appropriate chain of command, to include the Division Director of Community and Mental Health Services, regarding the circumstances. In these situations, the Division Director of Community and Mental Health Services, in consultation with the Chief of Mental Health Services, shall direct an appropriate course of action for each request.

Section VI - Criteria for Requesting Fourth Year of Treatment

A. Prior to a request for a fourth year of sex offender treatment a comprehensive psychosexual risk assessment shall be completed by the treatment provider and reviewed by the treatment team.
B. For youth in out-of-home placement, the treatment team, including the JSW, shall determine if the youth is in need of a fourth year of sex offender treatment.
C. For youth residing in the community, the JSW shall initiate the request for a fourth year of sex offender treatment after consultation with appropriate treatment providers.
D. A written request for a fourth year of treatment shall not be made unless one or more of the following factors are present:
    1. Persistent and recent refusal to comply with treatment requirements;
    2. Recent commission of a new sex offense or recent verbalization of intent to reoffend;
    3. Recent absent without leave (AWOL) from out-of-home placement; or
    4. Youth recently exhibiting high risk sexually acting out behavior while in treatment.
E. The following process shall be utilized when requesting a fourth year of sex offender treatment for youth in out-of-home placement:
    1. The youth's assigned residential counselor shall complete a written request and forward it through the chain of command to the Deputy Commissioner of Program Operations, or designee, for consideration. The request shall specify the basis for the need for a fourth year of sex offender treatment consistent with the requirements set forth in DJJPP Chapter 8 (Treatment Program for Declared Juvenile Sexual Offenders) and the youth's treatment needs.
    2. If the request is approved at the Deputy Commissioner level in consultation with the Chief of Mental Health Services, the residential counselor shall notify the DJJ Office of Legal Counsel and request a motion to be filed in the committing or sentencing court requesting the fourth year of sex offender treatment. The JSW shall assist in presenting the request to the committing judge for consideration. The youth's attorney, including the attorney from the Juvenile Post Disposition Branch if represented by the Department of Public Advocacy (DPA), shall also be provided notice of the motion in accordance with court rules.
F. The following process shall be utilized when requesting a fourth year of sex offender treatment for youth residing in the community:
    1. The JSW, after consultation with the JSDS, shall determine if the youth is in need of a fourth year of sex offender treatment.
    2. The JSW shall complete a written request for a fourth year of sex offender treatment and forward it through the chain of command to the Deputy Commissioner of Community and Mental Health Services or designee for consideration. The request shall specify the basis for the need for a fourth year of sex offender treatment consistent with the requirements set forth in DJJPP Chapter 8 (Treatment Program for Declared Juvenile Sexual Offenders) and the youth's treatment needs.

3. If the request is approved at the Deputy Commissioner level in consultation with the Chief of Mental Health Services, the JSW shall notify the DJJ Office of Legal Counsel requesting a motion to be filed in the committing or sentencing court requesting the fourth year of sex offender treatment. The youth's attorney shall also be provided notice of the motion in accordance with court rules.

Section VII - Utilization of Polygraph Examinations

Polygraph examinations, if used, shall be performed in accordance with DJJPP Chapter 8 (Polygraph Examinations).

Section VIII – Youthful Offender Sexual Offender Registry

A. The JSW shall complete the Sex Offender Duty to Register Notification Form P227 as required by 502 KAR 31:020 on any YO who pleads guilty or is convicted of a "Sex Crime" as defined in KRS 17.500(8); a "criminal offense against a victim who is a minor" as defined in KRS 17.500(3)(a), or is required to register pursuant to KRS 17.510. The JSW shall ensure that the offender signs the form.

B. The Sex Offender Duty to Register Notification Form shall be forwarded to the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road Frankfort, KY 40601 and to the sentencing court with the Presentence Investigation Report. See KRS 17.510(3).

C. Information on the Sex Offender Duty to Register Notification Form shall be verified by the Presentence Investigation Report, if available.

D. The Superintendent or designee of the DJJ program in which the youth is housed shall inform any YO convicted of offenses outlined in KRS 17.500(3)(a) or KRS 17.500(8) or required to register pursuant to KRS 17.510 of the duty to register and shall require the youth to read and sign the Sex Offender Duty to Register Notification Form P227 provided for that purpose, prior to his release, pursuant to KRS 17.510(3). A copy of the form shall be maintained in the youth's file and the original shall be sent, along with a copy of the original at the time of sentencing, to the Department of Juvenile Justice Administrator of the Sex Offender Tracking System for forwarding to the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road Frankfort, KY 40601.

E. On or before the date of the offender's release by the court, the parole board, the cabinet, or any detention or residential facility, the registrant shall register with the appropriate local probation and parole office in the county in which he or she intends to reside as required by KRS 17.510 (2).

F. If the JSW determines that the offender did not comply with the registration requirements, the worker shall notify the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road, Frankfort, KY 40601. Documentation of the notification shall be maintained in the youth's file and shall be sent to the DJJ Sex Offender Tracking System Administrator.

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

KENTUCKY

Treatment Program for Declared Juvenile Sexual Offenders

JUSTICE AND PUBLIC SAFETY CABINET DEPARTMENT OF JUVENILE JUSTICE POLICY AND PROCEDURES	**REFERENCES: 505 KAR 1:160; 4-JCF-5C-01; 3-JCRF-5C-01**
CHAPTER: JUVENILE SEXUAL OFFENDER TREATMENT PROGRAM	**AUTHORITY: KRS 15A.065 KRS 635.500**
SUBJECT: Treatment Program for Declared Juvenile Sexual Offenders	
POLICY NUMBER: 801	
TOTAL PAGES: 2	
EFFECTIVE DATE: 11/01/2019	
APPROVAL: Raymond F. DeBolt ,COMMISSIONER	

I. POLICY

The treatment program for declared juvenile sex offenders (JSOs) shall be based on guiding principles that are consistent with an evidenced based framework that supports effective care. Department of Juvenile Justice Policy and Procedures (DJJPP) Chapter 8 and the Standard Operating Procedures (SOP) Manual for the Treatment of Declared Juvenile Sexual Offenders shall only apply to declared JSOs and shall not apply to juveniles who have been adjudicated guilty of a sexual offense, but have not been declared a JSO.

II. APPLICABILITY

This policy shall apply to all Department of Juvenile Justice (DJJ) programs, DJJ staff, and approved private providers or agencies providing services to declared JSOs.

III. DEFINITIONS

Refer to Policy 800.

IV. PROCEDURES

A. DJJ shall develop and implement a juvenile sex offender treatment program for declared juvenile sex offenders. Reference KRS 635.500 635.510. The treatment program shall be established in the SOP Manual for the Treatment of Declared Juvenile Sexual Offenders.

B. DJJ shall develop and implement a standardized process for the treatment of declared juvenile sexual offenders.

V. MONITORING MECHANISM

Monitoring of this policy and corresponding standard operating procedures shall be conducted by the Division Director of Community and Mental Health Services and the Quality Assurance Branch on an annual basis.

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

LOUISIANA

Assessment and Treatment of Youth Who Demonstrate Sexual Behavior Problems

YOUTH SERVICES
POLICY

Title: Assessment and Treatment of Youth Who Demonstrate Sexual Behavior Problems	**Type:** B. Classification, Sentencing and Service Functions **Sub Type:** 2. Classification **Number:** B.2.16
	Page 1 **of** 11
References: LA. R.S. 15:541; DOJ PREA Standard 115.341 (a); ACA Standards 2-CO-4F-01 (Administration of Correctional Agencies); 4-JCF-4D-02, 4-JCF-4D-03,4-JCF-5A-01, 4-JCF-5B-01, 4-JCF-5B-02, 4-JCF-5B-03, 4-JCF-5C-02, 4-JCF-5C-03, 4-JCF-5C-05, 4-JCF-5C-06, and 4-JCF-5C-07 (Performance-Based Standards for Juvenile Correctional Facilities); YS Policy Nos. B.2.2 “Youth Classification System and Treatment Procedures”, B.2.3 "Secure Care Intake", B.2.14 "Secure Care SAVRY", B.2.17 “Sex Offender Notification and Registration Requirements”, B.2.19 “Programs and Evidence-Based Practices”, C.2.11 "Prison Rape Elimination Act (PREA)”, C.4.1 "Furlough Process", D.9.1 “Placement of Youth in Residential Facilities”, D.10.32 "SAVRY-Community Based Services" and D.15.3 “Delivery of Treatment and Auxiliary Services”	
STATUS: Approved	
Approved By: *William A. Sommers, Deputy Secretary*	**Date of Approval:** 06/06/2022

I. AUTHORITY:

Deputy Secretary of Youth Services (YS) as contained in La. R.S. 36:405. Deviation from this policy must be approved by the Deputy Secretary.

II. PURPOSE:

To set forth uniform policy and broad procedures governing direct admission and assessment or evaluation of youth, who have been adjudicated for a sexual offense and/or evidences the need for mitigating the sexual offending risk, and to guide the type of “Sexual Behavior Problem Treatment Program” (SBPTP) they shall engage in.

III. APPLICABILITY:

Deputy Secretary, Assistant Secretary, Chief of Operations, Executive Management Advisor, Probation and Parole Program Director, Secure Facilities Director, Director of Treatment and Rehabilitation, Central Office (JUMP) Sexual Behavior Problem Treatment Program (SBPTP) Clinical Supervisor, Health Services Director (HSD), Regional Directors, Facility Directors, Regional Managers and the Contracted Health Care Provider (CHP).

IV. DEFINITIONS:

Contracted Health Care Provider (CHP) – Contracted licensed practitioners responsible for the physical and mental well-being of the secure care youth population. Services include medical, dental, and mental health services, nursing, pharmacy, personal hygiene, dietary services, health education, and environmental conditions.

Hands-On Sex Offense – Sexual activity which involves the touching of another person (children, peer or adult) or animal on certain parts of the body. The sexual contact may be anal, oral or vaginal and include human contact or the use of a foreign object.

JUMP (Juvenile Understanding and Managing Problems) - Best practice model of treatment for youth who have demonstrated sexual behavior problems; the treatment model includes the following treatment components: Clinic-Based and Dorm-Based Treatment Programs for youth in secure care.

Psychosexual Assessment - An evaluation that focuses on a youth's sexual development, sexual history, paraphilic interests, sexual adjustment, risk level, antisocial history, acceptance of responsibility for the offense, desire to change, empathy for the victim, remorse for the offense, and victimology. It also includes a complete social; school, family and other relevant history; case formulation; and specific recommendations for treatment.

Secure Care Facility – "A living environment characterized by a range of moderate to high security level facilities that include construction, fixtures and staff supervision designed to restrict the movements and activities of the residents, and to control, on a 24-hour basis, the ability of the residents to enter and leave the premises, and which are intended for the treatment and rehabilitation of children who have been adjudicated delinquent." [La. Ch. Code Article 116(24.2)]

The secure care facilities operated by YS are as follows:

- Acadiana Center for Youth (ACY)
- Acadiana Center for Youth at St. Martinville (ACY-SM)
- Bridge City Center for Youth (BCCY)
- Swanson Center for Youth (SCY)
- Swanson Center for Youth at Columbia (SCYC)

However, only BCCY, SCY and SCYC are applicable to this policy.

V. POLICY:

It is the Deputy Secretary's policy that individual program planning for youth adjudicated for a sexual offense shall include, as its primary objectives, the provision of protection for the public, staff and youth; a reduction of the risk to demonstrate future sexual behavior problems and other delinquent behavior; and the enhancement of youth growth and development.

This may be accomplished through the coordinated efforts of Community Based Services (CBS); contracted mental health providers completing assessments and providing mental health services; efforts to foster the continuum of services and supervision that identifies youth for treatment; careful consideration and selection of treatment providers; fostering the engagement of youth in prosocial activities; and implementing a continuum of services and supervision.

VI. PROCEDURES:

A. All youth assigned to YS custody or supervision and have been adjudicated delinquent or Family in Need of Services (FINS) for a sexual offense under La. R.S.15:541 [see Attachment B.2.16 (a)], which includes "hands on" sexual offenses against children, peers, adults and animals, and “non-hands-on” sex offenses such as exhibitionism and sexting, shall be referred for a psychosexual assessment to be completed by the CHP psychologist, CBS Social Services, or contracted community treatment provider. OJJ does not have the authority to provide assessment or treatment to youth prior to adjudication. Psychosexual assessments should be conducted subsequent to adjudication and prior to disposition. However, if a youth has been adjudicated and gone to disposition a psychosexual assessment must be completed for the youth prior to the initiation of treatment.

If psychosocial and psychosexual assessments have been conducted within six (6) months of the youth’s admittance to a YS Secure Care facility, there is no need to repeat these assessments unless the youths' presenting behavior and/or new information warrants a current evaluation.

While the majority of youth evaluated are those who have been adjudicated for a sexual offense, youth assigned to a secure or non-secure facility with demonstrated sexual behavior problems shall be considered for a psychosexual assessment when there is clear evidence of a history of sexually abusive behavior and the youth agrees to undergo a psychosexual assessment.

B. The SAVRY is NOT intended to predict reoffending risk for youth below the age of twelve or sex offenders based on past behavior and experiences. The SAVRY shall not be used as a means to estimate risk of sexual reoffending. The SAVRY estimates risk for general violence and general delinquent reoffending only. Many youths who display sexual behavior problems are low risk for general violence and general delinquent reoffending. This does NOT mean they are low risk of reoffending sexually. (Refer to YS Policies D.10.32 and B.2.14)

C. When youth placed in YS custody or supervision require a psychosexual assessment, the PPO/J shall complete the referral within five (5) working days of receiving notification of the disposition from the court.

The PPO/J shall complete the "Psychosexual Referral Form" [Attachment (b)] and forward it to the CO SBPTP Clinical Supervisor, CO CBS Clinical Supervisor and Regional Manager along with the PDI/Social History, educational reports, psychological, psychiatric or previous psychosexual evaluations, police report and court order (if applicable). The Social History or Supplemental Social shall be completed by the PPO/J and provided to the CO CBS Clinical Supervisor, CO SBPTP Clinical Supervisor and treatment provider in order to complete the assessment within the 30 working days timeframe.

D. If the youth is not adjudicated for a "hands on" or "non-hands-on" sexual offense and the court orders a psychosexual assessment or the youth to participate in the SBPTP, the CBS Regional Manager or designee shall contact the CO SBPTP Clinical Supervisor to determine how to proceed.

E. The psychosexual assessment, shall be completed by the CHP psychologist, CBS social services or contracted community treatment provider within 30 working days of request, utilizing the following YS approved assessment instruments indicated:

1. Hostility Toward Women (HTW)*;*
2. Adolescent Cognition Scale (ACS);
3. Adolescent Sexual Interest Cardsort (ASIC);
4. Inventory of Callous Unemotional Traits (ICU);
5. Juvenile Sex Offender Assessment Protocol - 11 (J-SOAP-II or MEGA); and
6. Child and Adolescent Needs and Strengths – Sexual Development.

If, due to the youth's cognitive impairments, an instrument not listed above should be used, the clinician completing the assessment shall consult with the CO SBPTP Clinical Supervisor to identify the appropriate course of action needed to satisfy completion of the evaluation.

F. Upon completion of the psychosexual assessment, the clinician shall forward the report to the CO SBPTP Clinical Supervisor for review. The assessment shall also be sent to the CO CBS Clinical Supervisor when completed by a CBS Social Services Staff member. Upon approval, the clinician shall forward the signed psychosexual report to the PPO/J, Regional Manager, Secure care SBPTP Program, Case Manager (if applicable) and CO SBPTP Clinical Supervisor.

G. If there are delays in receiving completed psychosexual evaluations within the stated timeframe, the CO SBPTP Clinical Supervisor shall contact the YS Secure Care HSA or CO CBS Clinical Supervisor who shall implement corrective actions immediately. Notice of the corrective actions taken shall be provided to the CO SBPTP Clinical Supervisor.

If the matter has not been resolved in a timely manner, a formal monitoring plan with timelines shall be instituted by the CO CBS Clinical Supervisor and Regional Manager or CO HSD (when applicable) with input from the CO SBPTP Clinical Supervisor to correct the deficiencies.

VII. PROVISION OF SERVICES

A. SBPTP - Community-Based and Non-Secure Care

1. Upon completion of the psychosexual assessment, if it is recommended a youth participate in the SBPTP and the youth will remain in the community or be assigned to a non-secure facility, notification will be sent by the CO SBPTP Clinical Supervisor to the CO CBS Clinical Supervisor and Social Service staff member or the Community Contracted Treatment Provider to initiate services.

2. The treatment provider shall complete the SBPTP Treatment Plan which will include the frequency of individual, family and group sessions (when applicable). The plan shall be completed within 7 days of case assignment and the parent/guardian shall be allowed to participate in the development. The plan shall be signed and dated by the youth and parent/guardian and updated when goals and objectives are met, new goals are added and upon completion of a module.

3. Youth participating in the community based SBPTP shall attend individual sessions at least twice a month and participate in a family session at least once monthly with a licensed therapist. Additional individual sessions may be clinically indicated as determined by the CO SBPTP Clinical Supervisor.

   Youth assigned to a non-secure facility who are participating in the SBPTP shall attend individual weekly sessions and participate in a family session at least once monthly with a licensed therapist.

When possible, group sessions shall be conducted weekly. Constraints such as distance, transportation, school or not having enough youth at the same level of treatment may prevent group sessions from being feasible. Each individual, family and group session shall be 45 to 60 minutes in duration.

Each treatment module is typically six to eight weeks long but may vary depending on the youths' ability to internalize treatment concepts and their ability to use learned skills effectively. Treatment focuses on the following modules:

a. Healthy Sexuality;
b. Social Skills;
c. Healthy Masculinity;
d. Impulse Control;
e. Anger Management;
f. Empathy Enhancement; and
g. Relapse prevention.

Youth assigned to a non-secure program shall complete treatment modules a) through e) prior to being recommended for release from YS custody to their parent/guardian. Refer to YS Policy B.2.1 "Assignment, Reassignment, and Release of Youth" for additional release criteria.

4. Youths participating in the SBPTP while remaining in the community or assigned to a non-secure facility, will be reappraised by the treatment provider every six (6) months subsequent to the initiation of treatment. The treatment provider shall forward the reappraisal to the Regional Manager, PPO/J, CO SBPTP Clinical Supervisor and CO CBS Clinical Supervisor. Refer to YS Policy 15.3 "Delivery of Treatment and Auxiliary Services" for other specific documentation requirements.

   If there is a change in the youth's physical location and the youth is not able to continue services with the current treatment provider, the assigned PPO/J shall notify the CO SBPTP Clinical Supervisor, CO CBS Clinical Supervisor, and CBS Social Worker or Contracted Community Treatment Provider, whichever is applicable, within five (5) working days of the location change.

5. The treatment provider shall forward the completed "Monthly Summary Report" (Attachment c) to the CO SBPTP Clinical Supervisor, CO CBS Clinical Supervisor, Regional Manager and PPO/J on a monthly basis.

B. JUMP SBPTP – Secure Care Staffing

1. If a youth is assigned to a YS Secure Care facility, upon completion of the psychosexual assessment, the CO JUMP SBPTP Clinical Supervisor shall direct the JUMP SBPTP Program Manager, treatment provider and/or Case Manager to schedule a multidisciplinary team staffing within 48 hours (excluding weekends and holidays), if there are no extenuating circumstances, to review the assessment reports for treatment and placement recommendations.

2. If current psychosexual and psychological assessments are not warranted, a multidisciplinary staffing shall be scheduled within 48 hours (if there are no extenuating circumstances), of receipt of the youth's most current psychosexual and psychological assessments to review placement and treatment recommendations.

3. If the extenuating circumstance(s) impacts the team's ability to convene within 48 hours, the team shall convene within 24 hours after the crisis has been resolved. If the team members fail to convene within the 24 hour period, the CO SBPTP Clinical Supervisor shall be provided an explanation by the facility Treatment Director and the YS Secure Care Health Services Administrator (HSA).

   Staff required to attend the multidisciplinary team staffing shall include the following:

   1. CO JUMP SBPTP Clinical Supervisor;
   2. CHP psychologist or designee completing the assessment or evaluation (via phone or in person);
   3. Facility SS Supervisor;
   4. Facility JUMP SBPTP team;
   5. Facility JUMP SBPTP team from the sending facility, if applicable; and
   6. Mental Health Treatment Staff, if applicable.

   The multidisciplinary team staffing shall be documented on a "IIP Summary of Staffing" form in JETS within seven (7) working days, and a hard copy with signatures placed in the youth's Master Record under Clip II.

4. The level of appropriate treatment to address the youth's sexual behavior problem is decided at the multidisciplinary team staffing, and may include a recommendation for either the JUMP clinic-based treatment program at Swanson Center for Youth (SCY) or the intense dorm-based or clinic-based treatment program located at Bridge City Center for Youth (BCCY).

5. If the youth is staffed at BCCY and recommended for dorm-based treatment [see Section VII.D of this policy], the youth shall be placed in the JUMP Program within 24 hours. If no sexual behavior treatment dorm-based bed is available, the youth shall be placed on a waiting list and transitioned to the dorm-based treatment program as soon as a bed is accessible. In the interim, the youth shall receive the dorm-based treatment while he is awaiting placement in the dorm that treats youth who have demonstrated sexual behavior problems.

   If the youth is recommended for clinic-based, the youth shall remain at or transfer to the secure care facility closest to the location of the youth's family for treatment.

6. The HSA and the CHP psychologist shall be notified of all scheduled staffings to ensure that either the psychologist or a designee attends the staffing. The CO SBPTP Clinical Supervisor shall inform the HSA if the psychologist/designee is not present for the staffing.

   The HSA shall immediately put corrective measures into place, forwarding a copy to the CO SBPTP Clinical Supervisor and the CO HSD. If attendance is not resolved, a formal monitoring plan shall be instituted by the CO HSD, with input from the CO SBPTP Clinical Supervisor to correct the deficiencies.

C. JUMP SBPTP Clinic-based

1. Youths in Clinic-based treatment are housed in general population dorms. These youths participate in one individual and group counseling session weekly and at least one family counseling session monthly with a licensed therapist. The sessions are 45 to 60 minutes in duration. Each treatment module is typically six to eight weeks long but may vary depending on the youths' ability to internalize treatment concepts and their ability to use learned skills effectively. The clinic-based treatment modules include the following:

   a. Healthy Sexuality;
   b. Social Skills;
   c. Healthy Masculinity;
   d. Impulse Control;
   e. Anger Management;
   f. Empathy Enhancement; and
   g. Relapse prevention.

2. Youths in clinic-based treatment are reappraised after they complete Phase II treatment modules if they are demonstrating they have internalized treatment at an emotional level and are using learned skills effectively. Upon completion of the reappraisal, the treatment provider shall forward a copy to the youth's case manager, PPO/J, Regional Manager and the CO SBPTP Clinical Supervisor.

3. Youth participating in clinic-based treatment shall complete Phase II treatment modules prior to being recommended for reassignment to a non-secure facility or release from YS custody to his/her parent/guardian. Refer to YS Policy B.2.1 "Assignment, Reassignment, and Release of Youth" for additional release criteria.

D. JUMP SBPTP Dorm-based

1. Treatment includes individual and group counseling weekly and family counseling with a licensed therapist. In dorm-based treatment youths participate in three weekly groups, one weekly individual therapy session, and family therapy once monthly. Individual, group and family sessions are 45 to 60 minutes in duration.

   There are four phases of treatment that are presented sequentially. Concepts presented in each phase are building blocks for subsequent phases. Each treatment phase, except phase IV, is 12 weeks long. Phase I, II and III include the following treatment modules:

   a. Phase I: Social Skills, Impulse Control and Healthy Masculinity I
   b. Phase II: Anger Management, Healthy Sexuality and Healthy Masculinity II
   c. Phase III: Empathy Enhancement, Relapse Prevention and Healthy Masculinity III
   d. Phase IV: Aftercare – Youths begin this phase of treatment after they have completed the aforementioned core treatment modules. In this phase of treatment youths continue to focus on skills they have learned, relapse prevention, independent living training and may serve as mentors for their peers. Youths remain in Aftercare until they leave a YS Secure facility unless they opt out of this treatment service.

2. After completing phase II, youths who are demonstrating they have internalized treatment concepts and who are not mandated to remain in secure care until age 21 will be reappraised to determine their current level of risk, treatment needs and placement recommendations. The reappraisal is conducted by an Office of Juvenile Justice master-level treatment provider. Youths who must remain in secure care are reappraised prior to their exit from the secure care facility.

Upon completion of the reappraisal, the treatment provider shall forward a copy to the CO SBPTP Clinical Supervisor, Secure Care Case manager, Regional Manager and PPO/J.

3. Youth participating in JUMP SBPTP Dorm-based treatment shall complete Phase I and II modules prior to being recommended for reassignment to a non-secure facility or release from YS custody to his/her parent/guardian. Refer to YS Policy B.2.1 "Assignment, Reassignment, and Release of Youth" for additional release criteria.

4. When a youth is reassigned to a non-secure program or granted an early release and requires continued treatment, the PPO/J shall complete the "Psychosexual Referral Form" [Attachment (b)] and forward to the CO SBPTP Clinical Supervisor, CO CBS Clinical Supervisor and Regional Manager with the required documentation within five (5) working days of release.

VIII. SAFETY PLAN CONTRACT AND REGISTRATION REQUIREMENTS:

A. Youth who are participating in community-based treatment and have been adjudicated for a hands-on sex offense or hands-on sex offense that has been pled down to a non-sex offense or a non-hands-on-sex offense must have a signed "Safety Plan" [Attachment (d)] in place when the following occurs:

1. The youth's disposition is probation with YS/OJJ supervision.
2. The youth is under a Deferred Disposition Agreement and YS/OJJ is supervising the youth.

B. Youth who are assigned to a secure or non-secure facility and have been adjudicated for a hands-on sex offense, or a hands-on sex offense that has been pled down to a non-sex offense must have a signed "Safety Plan" [Attachment (d)] in place prior to the occurrence of any the following:

1. Release from a secure care facility;
2. Placement in or release from a non-secure facility; and
3. Furlough or home pass.

C. The safety plan shall be created by the treatment provider with input from probation and/or other relevant staff such as mental health, when applicable, and must be signed by the youth, parent(s)/guardian(s) and the PPO/J. The "Safety Plan" [Attachment (d)] must be updated as needed or when changes in the youth's status have the potential to negatively impact the public and/or the youth's safety.

D. Refer to YS Policy B.2.17 "Sex Offender Notification and Registration Requirements" to ensure all necessary steps are taken prior to a youth's furlough, home pass, reassignment or release from YS custody.

IX. QUALITY ASSURANCE:

1. The CO JUMP SBPTP Clinical Supervisor shall notify the ACY, BCCY or SCY HSA, the HSD, the Director of Treatment and Rehabilitative Services, and Continuous Quality Improvement Services (CQIS) of any requests for corrective action and/or unresolved deficiencies from either the facility or the CHP psychologist for quality assurance purposes.

2. Documentation shall be provided in conjunction with the secure care quarterly treatment reviews for reporting purposes.

3. The Correctional Program Checklist (CPC) is an evidence-based tool developed to assess correctional intervention programs. The CPC is used to ascertain how closely correctional programs meet the known "Principles of Effective Intervention". In an effort to assure program integrity and facilitate opportunities for ongoing quality improvement, YS shall conduct CPC evaluations as outlined in the timelines in YS Policy B.2.19 "Programs and Evidence-Based Practices".

4. The CO CBS Clinical Supervisor shall be responsible for conducting quality assurance reviews of cases that are assigned to the CBS social service staff on a bi-annual basis (January/July). Quality Assurance reviews shall be conducted on-site and via JETS. (Refer to YS Policy D.15.3)

   The quality assurance tool authorized by CO shall be utilized to document review findings. The tools may be accessed through OJJ Share Point by logging on to http://oydcosps/default.aspx, and choosing the Continuous Quality Improvement Services (CQIS) tab.

Previous Regulation/Policy Number: B.2.16
Previous Effective Date: 03/17/2021
Attachments/References: B.2.16 (a) List of Sex Offenses February 2020
B.2.16 (b) Psychosexual Assessment and SBPTP Referral Form Dec 2018
B.2.16 (c) Community-Based Treatment Program Monthly Summary Dec 2018
B.2.16 (d) Safety Plan Example February 2020

List of Sex Offenses
La. R.S. 15:541

Statute	Description
14:40.2	Stalking of a victim under 18 years of age and the defendant is not the parent of the victim
14:42	First Degree Rape *occurring on or after August 1, 2015*
14:42	Aggravated Rape *occurring prior to August 1, 2015(Includes former 14:43.4 Aggravated Oral Sexual Battery prior to August 15, 2001)*
14:42.1	Second Degree Rape *occurring on or after August 1, 2019*
14:42.1	Forcible Rape *occurring prior to August 1 , 2015*
14:43	Third Degree Rape *occurring on or after August 1, 2015*
14:43	Simple Rape *occurring prior to August 1, 2015*
14:43.1	Sexual battery
14:43.1	Sexual battery of minor under 18 years of age
14:43.1(C)(2)	Sexual battery of a child under 13 years of age
14:43.2	Second degree sexual battery
14:43.3	Oral sexual battery
14:43.5	Intentional exposure to aids
14:44	Aggravated kidnapping of a minor
14:44.1	Second degree kidnapping of a minor under 18 years of age
14:44.2	Aggravated kidnapping of a child
14:45	Simple kidnapping of a minor under 18 years of age
14:45.1	Interference with child custody of a victim under 18 years of age and the defendant is not the parent of the victim

14:46	False imprisonment of a victim under 18 years of age and the defendant is not the parent of the victim
14:46.1	False imprisonment with a weapon of a victim under 18 years of age
14:46.2(B)(2)	Human trafficking
14:46.3	Trafficking of children for sexual purposes
14:78	Incest *[repealed by Acts 2014, No. 77 and 607]*
14:78.1	Aggravated incest *[repealed by Acts 2014, NOS.77 and 607]*
14:80	Felony carnal knowledge
14:81	Indecent behavior with juveniles
14:81.1	Pornography involving juveniles
14:81.2	Molestation of a juvenile or a person with a physical or mental disability
14:81.3	Computer aided solicitation of a minor
14:81.4	Prohibited sexual conduct between educator and student
14:81.2(D)(1)	Molestation of a juvenile or a person with a physical or mental disability prosecuted under the provisions of R.S. 14:81.2(C)(1), (D)(1), or (D)(2)
14:82.1	Prostitution: persons under 18 years of age
14:82.2 (C)(4)	Purchase of commercial sexual activity from persons known to be under 18 years of age or Human Trafficking of Children for Sexual Purposes when the victim is under 21 years of age.
14:82.2 (C)(5)	Purchase of Commercial Sexual Activity from a person known to be under the age of 14
14:83	Soliciting for prostitutes when the persons being solicited for prostitution are under 18 years of age
14:83.1	Inciting prostitution when the prostitution involves persons under 18 years of age.

14:83.2	Promoting prostitution when the prostitution being promoted involves persons under 18 years of age
14:84(A)(1), (3), (5), and (6)	Pandering when victim is under 18 years of age
14:86	Enticing of minor into prostitution
14:89	Crimes against nature
14:89	Crimes against nature when the victim is under 18 *excluding circumstances(B)(2) or (3)*
14:89(B)(2) or (3)	Crime Against Nature except when victim is a minor as provided (B)(2) and (3)
14:89.1(A)(1) or (2)	Aggravated Crime Against Nature involving prohibited relative as victim and *involving sexual intercourse, 2nd degree sexual battery, or oral sexual battery OR when bill of information or indictment specifically alleges victim under age 13 (14:89(C)(2)).*
14:89.1(A)(2)	Aggravated crime against nature *under circumstances not defined as an aggravated offense*
14:89.3	Sexual abuse of an animal *(2nd or subsequent conviction only)*
14:92(A)(7)	Contributing to the delinquency of juveniles
14:93.5	Sexual battery of the infirmed
14:106(A)(5)	Obscenity through solicitation of a minor
14:282	Operation of places of prostitution when the prostitution involves persons under 18 years of age
14:283	Video voyeurism
14:283.1	Voyeurism
23:251	Minors under 16 years of age: prohibited employments or occupations

Note: Deferred adjudication, adjudication withheld or an adjudication for the perpetration, attempted perpetration or conspiracy to commit one of the offenses listed above shall be considered a sex offense.

Psychosexual Assessment and SBPTP Referral Form

Youth's Name: _____

Client ID: # _____

Date of Birth: _____ Gender: _____

Current Location/Facility and Region: _____

Parent/Guardian: _____

Contact Information: _____

Referred for:
___ Psychosexual Assessment
___ Sexual Behavior Problem Treatment Program (SBPTP)

Attachments: (check all that apply)
___ Court order
___ Police Report
___ Previous Psychosexual Assessment
___ Reappraisal
___ Psychological/Psychiatric Evaluation
___ PDI/Social History/Supplemental Social
___ Safety Plan (if applicable)
___ Other: _____

Referred by: _____ Date: ___/_____/_____

Please forward the referral and all attachments to the CO SBPTP Clinical Supervisor, CO CBS Clinical Supervisor and Regional Manager.

COMMUNITY-BASED SERVICES
Monthly Summary

Youth's Name:	JETS #	Reporting Month:

CURRENT PHASE: CURRENT MODULE(S):		COMPLETED MODULE(S):	
□ Social Skills	□ Healthy Masculinity	□ Social Skills	□ Healthy Masculinity
□ Orientation	□ Healthy Sexuality	□ Orientation	□ Healthy Sexuality
□ Impulse Control	□ Anger Management	□ Impulse Control	□ Anger Management
□ Relapse Prevention	□ Empathy Enhancement	□ Relapse Prevention	□ Empathy Enhancement

NUMBER OF SESSIONS HELD:			NUMBER OF MISSED SESSIONS:		
__ Individual	__ Group	__ Family	__ Individual	__ Group	__ Family
__ Parenting			__ Parenting		
Date/Location for each:					

COMMENTS:

Note: Include dates for all other activities including psychosexual assessment\reappraisal, case staffing, court appearances, case consultation, collateral contacts

PROGRESS TOWARDS TREATMENT GOAL/OBJECTIVES:

□ SATISFACTORY □ FAIR □ POOR

COMMENTS:

_____ _____

THERAPIST'S SIGNATURE **DATE**

Revised 12/2018

SAFETY PLAN EXAMPLE

The "Safety Plan" shall be specific to the youth, their risk, include any restrictions that are mandated by the court or law and be signed by the youth and parent/guardian. The "Safety Plan" must be updated as needed or when changes in the youth's status have the potential to negatively impact the public and/or the youth's safety.

Reason for the Safety Plan:

Non-Secure or Secure Home Pass/Furlough:
(Youth's Name) is being released from **(Facility name)** to the care of the youths parent/guardian, **(Parent/Guardian's Name)**. Therefore, for the youth's safety and the safety of others a written plan is warranted to support the youth in successful reintegration into the home and community.

Community Based:
(Youth's Name) is currently residing with their parent/guardian, **(Parent/Guardian's Name)**. Therefore, for the safety of the youth and others a written plan is warranted to provide support while the youth remains in the home and community.

Rules and Expectations – We agree to the following:

1. **(Youth's Name)** will be supervised by an adult when the youth is around younger children under the age of 13 and/or any vulnerable individuals in the home, school and community such as someone who is mentally compromised.

    - **(Parent/Guardian's Name)** will ensure the youth has an adult supervising the youth at all times when the youth is in the company of younger peers or someone who is vulnerable, i.e., mentally compromised in the home, school and community.
    - If youth is found alone with a younger child or someone who is vulnerable, i.e., mentally compromised in the home, school and community, the youth's Probation Officer (P.O.) will be notified immediately.

2. **(Youth's Name)** will avoid settings in the community where younger children frequent i.e. parks, amusement parks, swimming pools, youth ball games, unless supervised by an adult.

    - **(Parent/Guardians Name)** will **not** grant requests by the youth to go to these types of places unless an adult has been designated to attend who will supervise the youth at all times.

- If the youth has gone to such settings without permission/supervision by an adult, his P.O. will be notified immediately.

3. **(Youth's Name)** will refrain from engaging in any activity which may adversely affect his and others' safety i.e. viewing pornography, highly sexualized movies/videos and inappropriate sexual dialogue in the home, school and community.

   - **(Parent/Guardians Name)** will provide adequate supervision, enable passwords/content blocks, and keep potentially risk-provoking materials away from the youth to insure compliance.
   - If the youth engages in this type of activity, his Probation Officer will be notified immediately.

4. **(Youth's Name)** shall not have any contact with his victim(s).

   - If the youth engages in this type of activity, his Probation Officer will be notified immediately.

5. **(Parent/Guardians Name)** will place alarms on **(Youth's Name)** bedroom door, window, etc.

Support System:

Support	Role	When to Contact	Contact Information
Parent/Guardian		Family Reintegration or Support	
Probation/Parole Officer		Immediately if one of these contract rules are violated	
Sex Offender Treatment Provider (SOTP)		Questions or concerns about his Sex Offender Treatment (SOTP)	
Sex Offender Treatment Provider		Questions about his current sex offender treatment	

(SOTP)			

This safety plan contract has been reviewed and agreed to by:

_____ _____
Youth Date

_____ _____
Parent/Guardian/Caregiver Date

_____ _____
PPO/J Date

_____ _____
Treatment Provider Date

BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

GUIDING PRINCIPLES FOR

ILLINOIS

IDAHO

HAWAII

BY

MR. BLAKE BARNEY

🔑 Core Guiding Principles (Illinois SOMB – Juveniles)

1. Community safety is the highest priority

Sexual abuse is recognized as harmful.

Protection of victims and the community overrides all other considerations in policy and practice.

Illinois General Assembly

2. Mandatory, specialized evaluation for all juveniles

Every juvenile adjudicated for a qualifying sex offense:

Must receive a comprehensive, sex-offense–specific evaluation.

Evaluations are not generic—they must be tailored to juveniles.

Illinois General Assembly

3. Holistic, offense-specific assessment and treatment

Evaluation and treatment must:

Address the full range of sexually inappropriate behaviors (legal or illegal).

Provide a complete picture of the youth, including:

Strengths

Weaknesses

Risk factors

Developmental and psychosocial needs

This reflects a rehabilitative, developmental approach, not just punitive.

Illinois General Assembly

4. Multidisciplinary Team (MDT) approach

A team-based model is required, typically including:

Treatment providers

Probation/parole

Child welfare

Other relevant professionals

The MDT ensures:

Coordination of treatment, supervision, and management

Ongoing focus on victim safety and well-being

Illinois General Assembly

5. Individualized recommendations and case planning

The MDT is responsible for:

Recommending placement (home, residential, secure care)

Determining level of supervision

Recommending type and intensity of treatment

All decisions are risk- and needs-based, derived from the evaluation.

Illinois General Assembly

6. Family involvement is essential

The juvenile's family or caregivers must be involved in:

Decision-making

Treatment planning

Ongoing supervision strategies

This reflects the belief that family systems are critical to rehabilitation.

Illinois General Assembly

7. Goal: "No more victims"

All principles are organized around a central mission:

Prevent reoffending

Enhance community safety

Promote accountability and rehabilitation

🔑 Idaho – Guiding Principles for Juvenile Sex Offenders (SOMB)

1. Victim-Centered Priority

The rights, needs, and safety of victims and their families are paramount at every stage of the system.

Policies cannot be solely offender-focused. □

Idaho Supreme Court

2. Protection of Children (Especially Intrafamilial Victims)

Special emphasis on protecting children who have been sexually abused, particularly within family systems.

Their needs take priority over family preservation or parental interests when those conflict. □

3. Ongoing, Dynamic Process (Not One-Time Intervention)

Evaluation, assessment, and treatment are continuous processes, not one-time events.

Juvenile risk and needs change over time, requiring reassessment and adjustment. □

4. Assessment-Driven Case Management

All decisions (treatment, supervision, placement, restrictions) must be:

Individualized

Based on empirical risk assessment

Emphasis on matching level of intervention to risk and need. □

5. Risk Reduction and Community Safety Focus

The system is designed to:

Reduce risk of re-offense

Enhance public safety

Management strategies are grounded in risk management, not punishment alone. □

6. Developmentally Appropriate Approach

Juveniles are treated as developmentally different from adults:

Greater capacity for change

Behavior may be more situational and less entrenched

Interventions emphasize rehabilitation and skill development.

7. Strength-Based and Skill-Building Orientation

Treatment focuses on:

Building prosocial skills

Developing protective factors

Supporting a non-offending lifestyle □

8. Accountability with Rehabilitation

Juveniles are held accountable, but within a framework that:

Promotes learning and behavior change

Avoids purely punitive responses

Focus is on responsibility + capacity for change.

9. Multidisciplinary Collaboration

Effective management requires coordination among:

Courts

Probation/parole

Treatment providers

Families

Collaboration is essential to consistent supervision and treatment outcomes. □

10. Family and Community Involvement

Families are typically integral to treatment and supervision (when safe and appropriate).

Community systems play a role in reintegration and monitoring.

11. Informed Consent and Ethical Practice

Youth and guardians must receive:

Clear explanation of treatment

Informed consent/assent

Ethical, transparent practice is required throughout treatment.

Bottom Line

Idaho's model is built on a balanced framework:

Victim safety first

Risk-based, individualized management

Developmentally appropriate rehabilitation

Ongoing assessment and collaboration

It reflects a risk-need-responsivity (RNR)-informed approach tailored specifically to juveniles rather than simply adapting adult sex offender models.

🔑 Core Guiding Principles (Hawaii – Juvenile Sexual Offenders)

1. Community safety and reduction of victimization is the primary goal

The system is explicitly designed to:

“achieve safer communities by reducing sexual victimization”

All standards (evaluation, treatment, supervision) are built around:

Preventing harm to current and potential victims

Holding youth accountable

👉 This mirrors Illinois’ “no more victims” philosophy, but is stated more broadly in statute.

2. Statewide, integrated system of care (continuum model)

Hawaii requires a “statewide integrated system” of:

Assessment

Evaluation

Treatment

Supervision

This system must:

Follow a comprehensive master plan

Provide a continuum of services (from least to most restrictive)

👉 Key difference: Hawaii emphasizes system integration across agencies more explicitly than Illinois.

3. Multidisciplinary, interagency collaboration is mandatory

The system is implemented cooperatively by:

Department of Corrections

Judiciary

Department of Health and Human Services

The Sex Offender Management Team (SOMT) exists specifically to:

Coordinate assessment, monitoring, and intervention

Develop best-practice standards statewide

Hawaii Department of Corrections

👉 This is very similar to Illinois' MDT model, but Hawaii embeds it directly into statute and system design.

4. Risk- and needs-based assessment model

Hawaii requires:

A "unified and cohesive process of offender assessment"

Addressing both:

Risk to the community

Treatment needs

Hawaii State Legislature

"Assessment" is defined as evaluating:

Mental

Social

Motivational functioning

👉 This aligns closely with the Risk-Need-Responsivity (RNR) framework.

5. Evidence-based, standards-driven treatment and supervision

The system must:

Develop and implement statewide standards and guidelines

Use best practices for:

Evaluation

Treatment

Supervision

Ongoing responsibilities include:

Monitoring program effectiveness

Updating standards

Training providers

👉 This reflects a continuous quality improvement model, not a static system.

6. Accountability + rehabilitation (dual focus)

Standards must:

Hold youth accountable for behavior

While also providing treatment interventions

Hawaii State Legislature

Treatment is defined as:

Specialized interventions addressing psychological and behavioral factors

👉 Hawaii balances:

Public safety (control)

Rehabilitation (treatment)

7. Comprehensive management across settings (not just treatment)

Hawaii explicitly includes:

Supervision

Housing

Community transition

Interagency coordination

👉 This is broader than many states—management includes the entire lifecycle of the offender, not just therapy.

8. Ongoing evaluation, research, and system improvement

The Board/SOMT must:

Evaluate program effectiveness

Conduct research

Improve management practices

Hawaii State Legislature

👉 This creates a feedback loop:

Policy → Implementation → Evaluation → Revision

🧠 Key Takeaways (Big Picture)

Hawaii's juvenile sex offender framework is:

Safety-driven → reduce sexual victimization

System-integrated → one coordinated statewide model

Multidisciplinary → agencies must collaborate

Risk/needs-based → structured assessment guides decisions

Evidence-based → standards + continuous improvement

Accountability + rehabilitation balanced

Lifecycle-oriented → includes supervision, housing, reentry

⚖️ How Hawaii Differs from Illinois (Quick Insight)

More system-level focus → Hawaii emphasizes statewide integration and infrastructure

Less explicitly "juvenile-specific language" → principles apply to both adults and youth

Stronger statutory grounding → core ideas embedded directly in law rather than administrative code

Broader management scope → includes housing, transition, and interagency operations

🧠 Key Takeaways (Big Picture)

Illinois' approach is:

Safety-first → community protection is paramount

Developmentally informed → juveniles are treated differently than adults

Holistic → focuses on the whole youth, not just the offense

Team-based → multidisciplinary coordination is required

Family-centered → caregivers are part of the solution

Risk/needs driven → decisions are individualized, not one-size-fits-all

🧠 Big Picture Differences (What Actually Matters)

🟦 Idaho → Most Structured / Clinical Model

Highly standardized and prescriptive

Clear expectations for:

Evaluation tools

Treatment phases

Best described as:

“Clinical, structured, risk-driven management system”

🟩 Illinois → Most Juvenile-Centered / Developmental Model

Strong focus on:

Adolescent development

Family involvement

Holistic understanding of the youth

MDT plays a central decision-making role

Best described as:

“Developmentally informed, team-based rehabilitation model”

🟧 Hawaii → Most System-Integrated / Infrastructure Model

Focuses less on individual components and more on:

How the entire system works together

Emphasizes:

Statewide coordination

Continuum of care

Interagency collaboration

Best described as:

“Integrated statewide system with continuous oversight and improvement”

🔍 Key Practical Differences for Professionals

1. Evaluations

Idaho → Most structured (approved tools, specific protocols)

Illinois → Most flexible but still comprehensive

Hawaii → Focus on consistency across agencies rather than specific instruments

2. Treatment Planning

Idaho → Phase-based, offense-specific progression

Illinois → Individualized, developmentally responsive

Hawaii → Must fit within a continuum of statewide services

3. Decision-Making Authority

Idaho → Guided by structured standards + evaluator input

Illinois → MDT-driven decisions are central

Hawaii → Shared across interagency system (SOMT + departments)

4. System Strengths

Idaho → Consistency and defensibility (especially in court)

Illinois → Strong rehabilitation outcomes for youth populations

Hawaii → Coordination and long-term system accountability

🧩 Bottom Line

Idaho = Best for structure, consistency, and clinical rigor

Illinois = Best for juvenile-specific rehabilitation and family integration

Hawaii = Best for system-wide coordination and continuum of care