BACKGROUND MATERIAL

AZSOMB JUVENILE GUIDELINES AND STANDARDS SUBCOMMITTEE

April 16, 2026

JUVENILE SEX OFFENDER MANAGEMENT: FOUR-STATE COMPARISON

BY

MR. PETER MOREY

Juvenile Sex Offender Management: Four-State Comparison

Arizona Sex Offender Management Board — Juvenile Subcommittee Briefing

Washington State Most research-grounded

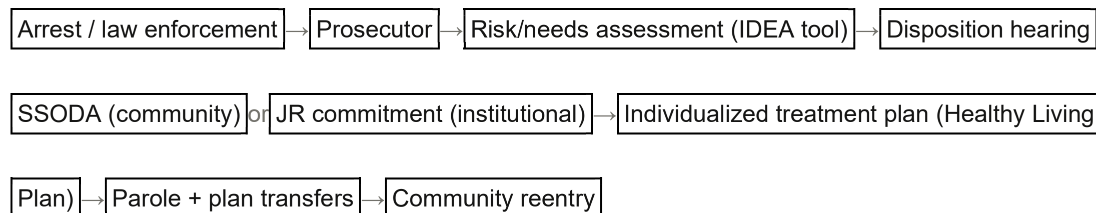
GOVERNING BODY

- DCYF (Dept. of Children, Youth and Families) — administers Juvenile Rehabilitation (JR)
- Sex Offender Policy Board (SOPB) — volunteer-only policy advisory body; convened by Legislature or Governor on assignment. Currently convened specifically on juvenile sex offender questions.
- ESHB 1394 (2023) — landmark legislation dramatically reducing juvenile registration requirements

CORE GUIDING PRINCIPLES (ON PAPER)

- Juveniles are a fundamentally distinct population from adults — policy must reflect ongoing brain development
- 5-year juvenile sexual recidivism rate is ~7%; most youth who offend do not continue once detected and treated
- Over-intervention is a recognized harm — intervention beyond actual risk level can increase reoffending
- Risk AND protective factors assessed together (family, school, peers, resilience) — not offense-based classification alone
- Least restrictive placement governs — community placement preferred; institutional commitment for higher risk only
- Treatment plan follows the youth from institution through parole — no restart at transition points

PIPELINE: ACCUSATION → REHABILITATION



- **SSODA:** First-time offenders amenable to treatment get community supervision + certified outpatient treatment + registration, minimum 24 months. No institutional commitment.
- **JR commitment:** Institutional treatment under Integrated Treatment Model (ITM) — CBT/DBT-informed, individualized, RNR-based. Group and individual modalities.
- **Registration:** Post-ESHB 1394, dramatically fewer offenses trigger registration. Juveniles still required to register get shorter timelines; failure to register reduced from felony to gross misdemeanor.

REALITY ON THE GROUND (2024–2025)

- Green Hill School: population 30% over safe capacity (240 vs. 180); intake suspended July 2024, counties sued, federal court involved
- Echo Glen: fencing added; judge stated "we went from a therapeutic environment to building a prison for children"
- 2025 legislature left session without structural fix — $3.5M security upgrades only; new Aberdeen facility delayed
- Treatment model is intact on paper; functionally compromised when units are on lockdown for safety incidents
- Fewer than 100 certified community treatment providers statewide — geographic gaps significant

Arizona takeaway: SSODA mechanism is directly transplantable. The 7% recidivism figure reframes fear-based conversations. Cautionary note: expanding who a system serves (JR to 25) without expanding capacity collapses the therapeutic model regardless of how sound the principles are.

Pennsylvania Strong at top of pyramid; thin below

GOVERNING BODY

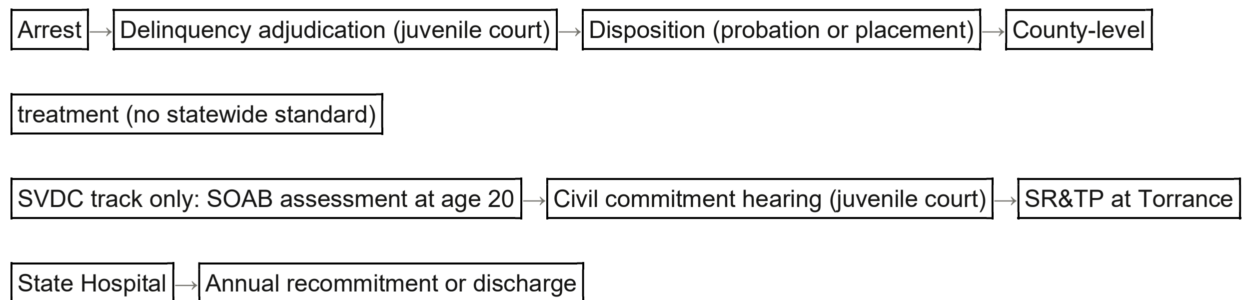
- Sexual Offenders Assessment Board (SOAB) — 76-member panel, Governor-appointed, handles all SVP and SVDC assessments
- Dept. of Human Services (DHS) — administers civil commitment at Torrance State Hospital (SR&TP)

- No standalone juvenile sex offender management board; no statewide standards for non-SVDC juveniles
- 67 counties each operate independently for general juvenile sex offender treatment

CORE GUIDING PRINCIPLES (JUVENILE — SVDC TRACK ONLY)

- Clients are individuals with specific treatment needs first — treatment and habilitation are primary goals
- Treatment interruptions should be minimized whenever possible
- Aftercare is a critical component — planning begins at time of referral, not discharge
- PTSD is explicitly named as prevalent in this population and requires its own intensive treatment plan
- Services must be culturally sensitive and updated per evidence-based best practices
- *Note: These six principles apply only to civilly committed youth (SVDCs). No comparable document exists for the general juvenile population.*

PIPELINE: ACCUSATION → REHABILITATION



- **Registration (post-In re J.B., 2014):** Pennsylvania Supreme Court struck down SORNA juvenile registration as unconstitutional — irrebuttable presumption of high risk violates due process. Juveniles no longer required to register EXCEPT if classified as SVDC. Most adjudicated juvenile sex offenders have no public registry presence.
- **SVDC civil commitment:** Requires mental abnormality or personality disorder causing serious difficulty controlling sexually violent behavior — a narrow, high-threshold finding. Commitment renewable annually, no fixed cap, right to attorney and independent expert at each hearing.
- **General population treatment:** County-by-county. SOAB approves individual providers but no unified standards govern the approach. Wide variability across 67 counties.

REALITY ON THE GROUND (2024–2025)

- SOAB panel robust at 76 members — assessment infrastructure at SVP/SVDC level is genuinely strong
- Torrance SR&TP operating; Act 21 pipeline unchanged since 2004
- Torsilieri (2024 PA Supreme Court): adult SORNA upheld; juvenile J.B. carve-out unaffected and still operative
- County treatment gap remains entirely unresolved — no legislative movement toward statewide juvenile standards

Arizona takeaway: Pennsylvania's explicit PTSD principle is worth adopting — naming trauma as prevalent in the population is a clinically important commitment. The SVDC pipeline mirrors Arizona's SVP civil commitment work. The county-level gap is a cautionary model for what happens without a central standards body for the general population.

Rhode Island Juvenile side stronger than adult side

GOVERNING BODY

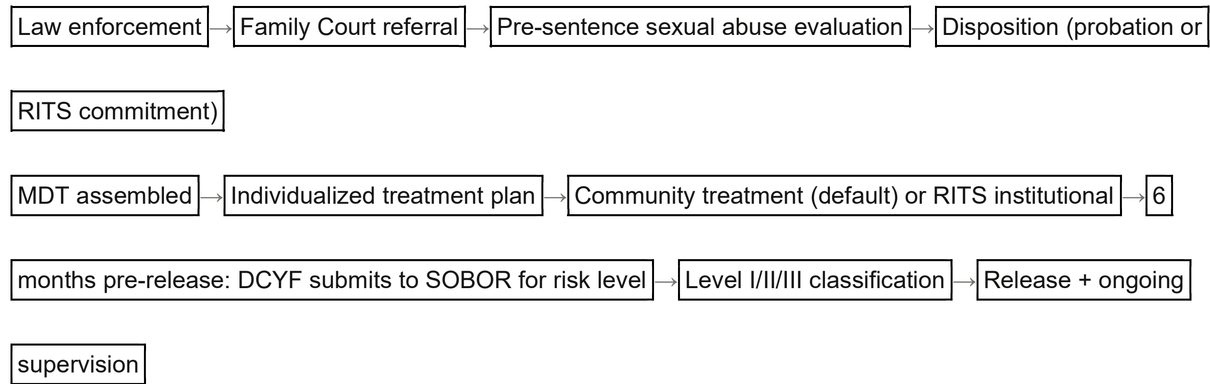
- DCYF — single integrated agency handling child welfare, behavioral health, AND juvenile corrections simultaneously
- Sex Offender Board of Review (SOBOR) — 8-member, Governor-appointed; risk classification and community notification only. Does not set treatment standards.
- No unified sex offender management board. No published adult treatment principles.
- Family Court — exclusive jurisdiction over juvenile delinquency matters

CORE GUIDING PRINCIPLES (JUVENILE — DCYF PRACTICE STANDARDS)

- Public safety and victim protection are primary goals
- Multidisciplinary team (MDT) required — treatment provider, DCYF worker, probation officer, caregiver all mandatory collaborators
- Treatment is individualized — each youth gets an individualized assessment before any treatment plan is written

- Caregiver is an active participant — not just notified, but involved in planning and progress reviews
- Victim safety governs all contact and reunification decisions — victim-driven, not automatic
- Discharge from treatment does not mean risk has been eliminated — management may continue
- Providers must be independently licensed, Medicaid-certified, and have 1,000+ supervised hours specifically with this population in the last five years

PIPELINE: ACCUSATION → REHABILITATION



- **Sexting carve-out:** §11-9-1.4 treats juvenile sexting as a status offense — no delinquency adjudication, no registration. Deliberately kept out of the formal system.
- **RITS:** Single secure facility in Cranston. Population declined 83% since 2008 (1,084 → 180 in 2024). Hard statutory cap of 148 boys / 12 girls per day. Small system = individualized programming possible.
- **Registration:** Juvenile convictions excluded from public website — law enforcement only. 15-year registration with quarterly verification for those required. Age-gap judicial discretion provision: if offense is criminal only because of victim's age, court may decline to order registration at all.
- **DCYF psychiatrist:** SVP evaluation for juveniles runs through DCYF medical staff — not Parole Board. Juvenile SVP track goes through Family Court, not Superior Court.
- **CYPSI:** RI selected as one of 6 states for federal initiative strengthening community-based diversion services (2024).

REALITY ON THE GROUND (2024–2025)

- Community treatment is the genuine default — RITS population is small and stable by design
- MDT model and provider credentialing standards are published, functional, and Medicaid-linked
- Racial disparity significant: Black youth 27% of RITS vs. 6% of child population; no affirmative disparity-reduction mandate unlike Washington
- Adult treatment side has no published principles — structural weakness that remains unaddressed

Arizona takeaway: Rhode Island's integrated single-agency structure (child welfare + juvenile corrections in one agency) reduces handoff failures for youth who are both offenders and abuse victims. The MDT requirement and provider credentialing floor are directly adoptable as Arizona principles. The public registry exclusion for juvenile convictions is a policy choice worth discussing.

Tennessee Cautionary reference model

GOVERNING BODY

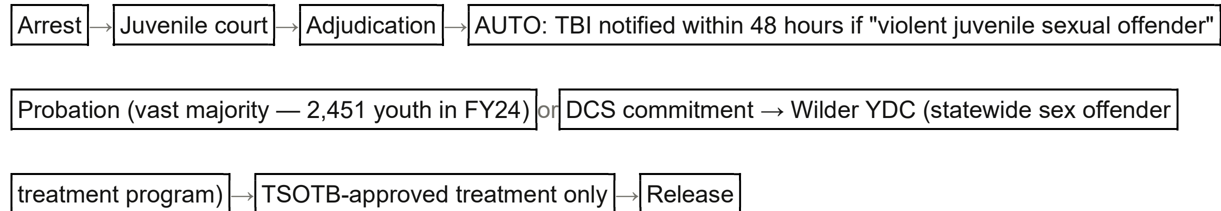
- Tennessee Sex Offender Treatment Board (TSOTB) — housed at TDOC; 12-member board; governs ALL sex offender treatment, adults and juveniles under a single unified framework
- Department of Children's Services (DCS) — must use only TSOTB-approved providers; has no authority to adopt a separate juvenile framework
- No juvenile-specific guiding principles document exists. No separate juvenile board.

CORE GUIDING PRINCIPLES (UNIFIED ADULT/JUVENILE — ON PAPER)

- No-cure policy is statutory (TCA §39-13-704) — measures of success must be built on a no-cure basis
- Offenders are "master manipulators" — apparent openness and progress should be treated with skepticism. Providers are directed to maintain this stance as a condition of approval.
- External legal mandate, not internal motivation, is the primary driver of compliance
- Polygraph is mandatory — required at regular intervals, results shared with supervision officers
- Objective testing required (plethysmography, ABEL Screen) — no evaluation is complete without psychophysiological measures

- Treatment is primarily group-based (weekly group model); individual therapy is supplementary only
- The Board is a victim advocacy body, not a treatment advocacy body — stated formally in treatment philosophy

PIPELINE: ACCUSATION → REHABILITATION



- **Registration:** Automatic and immediate at adjudication for qualifying offenses — no individual risk assessment required before registration. No judicial discretion at classification stage. Major residential restrictions (1,000-foot exclusions) do NOT automatically apply to juveniles unless court orders them — that is the only juvenile carve-out.
- **Constitutional pressure:** Doe v. Lee (6th Cir. 2024) struck retroactive application of Tennessee's most restrictive residency, travel, and in-person reporting provisions as Ex Post Facto violations. Case remanded, ongoing. Adult-focused but constitutional logic applies to juvenile registration arguments.
- **ATSA endorsement:** Board formally endorses ATSA 2014 standards — individual providers likely practicing more developmentally appropriately than TSOTB's headline philosophy suggests, because ATSA's own juvenile guidance is more calibrated. But state policy does not require it.
- **Only 42 youth in state custody (all offense types) in FY24** — the institutional population is small, but the one statewide sex offender treatment program runs through Wilder.

REALITY ON THE GROUND (2024–2025)

- Wilder YDC: subject to 2024 federal disability rights lawsuit (Disability Rights Tennessee) — youth in solitary confinement for months, suicidal ideation, 65–85% of population has a disability
- $185 million authorized to replace Wilder with two new facilities; construction begins 2027. Statewide sex offender treatment program runs in this facility in the interim.

- No legislative movement toward juvenile-specific treatment framework — none anticipated
- General juvenile recidivism rate improved to 12% in FY2024 — positive trend, but not sex-offense-specific data

Arizona takeaway: Tennessee is the negative reference point — the state that did the most things the research literature says not to do. The no-cure statutory mandate, the master manipulator framing, the adult-juvenile unified framework, the automatic registration with no individualized risk assessment — each of these stands in direct contrast to evidence-based best practice. Useful for showing the board the full range of where states land philosophically.

What this means for Arizona's juvenile subcommittee

Adopt from Washingtons SSODA-style community disposition alternative. Explicit over-intervention as a recognized harm. 7% recidivism anchor for board discussions. Protective factors alongside risk factors in assessment.

Adopt from Pennsylvania Explicit PTSD principle — name trauma as prevalent, require dedicated treatment planning. Robust assessment infrastructure for the highest-risk tier. Clear civil commitment pipeline with annual review rights.

Adopt from Rhode Island requirement with caregiver as active participant. Provider credentialing floor (licensed, Medicaid-certified, 1,000 hours with this population). Victim-driven contact/reunification decisions. Pre-sentence evaluation before disposition.

Avoid from Tennessee Unified adult/juvenile framework with no developmental differentiation. No-cure statutory language applied to adolescents. Automatic registration without individualized risk assessment. Adversarial treatment philosophy toward a treatment-amenable population.