NOTICE OF PUBLIC MEETING
ARIZONA SEX OFFENDER MANAGEMENT BOARD

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** (the "Board") and to the general public that the Board will hold a meeting, open to the public, on **April 20, 2026**.

The **April 20, 2026,** Board 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 20, 2026,** Board meeting:

Arizona State Capitol
1700 West Washington Street (Second Floor Conference Room)
Phoenix, Arizona

Virtual Meeting Access: Microsoft Teams Meeting: Join
https://teams.microsoft.com/meet/274356325921?p=dUJu8RUITubbOOZlQ1

Meeting ID: 274 356 325 921
Passcode: Yx2ha2ur
Dial in by phone: +1 480-536-7328,,426733265#
Phone conference ID: 426 733 265#

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

A copy of the meeting agenda is attached. The Board reserves the right to change the order of items on the agenda. One or more members of the Board may participate virtually.

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

Pursuant to A.R.S. § 38-431.03(A)(2), the Board 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 Board 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).

The **April 20, 2026,** Board meeting will be a hybrid-access meeting. Please see below on how to access the meeting and provide public comment on agenda items, regardless of the chosen access method.

To access the Board meeting virtually:
To watch the Board meeting via computer or a smartphone with a data plan:

- Click: Join OR
- Click on the following link: https://teams.microsoft.com/meet/274356325921?p=dUJu8RUITubbOOZlQ1OR
- Open a web browser on your device (Google Chrome, Safari, Internet Explorer, Firefox). Then, type or copy the above link into the address or search bar on your browser and press "Enter".

Procedures for Submitting a Request to Speak Form (Please read through each option carefully):
Public comments for the meeting will be accepted in written form or verbally during the meeting.

- **Written Public Comments:**
  - Written comments for the meeting will be accepted by:
    - Submitting a written public comment form available at: https://www.azdps.gov/form/somb-call-to-the-public-written-.
    - USPS to Arizona Department of Public Safety/AZSOMB P.O. Box 6488 Mail Drop 3230, Phoenix, AZ 85005. Please note that USPS mail takes time to be delivered. Please plan accordingly to ensure that the Board receives the written public comment by the deadline for the Board to receive a written comment set forth below.

  - **The deadline for the Board to receive a written comment is Friday, April 17, at 5 p.m.** Written comments received after the deadline, including those that are mailed but not received by staff, will not be posted and will not be provided to members.

  - Written comments will not be read into the record; however, staff will post all written comments received by the deadline on the Board's agenda by the deadline for the Board to receive a written comment set forth above.

- **Virtual Verbal Public Comments.** A virtual public comment is a public comment provided during the meeting via Microsoft Teams and wherein the person giving the public comment is not physically in person during the regular Board meeting**:**

  - Individuals planning to submit a virtual public comment **must submit a** request to speak form available at https://www.azdps.gov/form/somb-call-to-the-public-inperson to provide a virtual verbal public comment at the meeting during the Call to the Public agenda item.

  - **The deadline to submit a request to speak form to provide a virtual verbal comment is Monday, April 20 at 10 a.m.**

  - During the Call to the Public agenda item, those who submitted a request to speak form will be called on to speak virtually. The name in which you submit the form

MUST match the name on the account when signing into the meeting to speak. Prior to the meeting, you may need to download the Microsoft Teams application to your device and create an account to ensure name matching. Individuals who submit the form after the deadline on **Monday, April 20 at 10 a.m.** will not be provided the opportunity to give virtual verbal public comment at the meeting.

- **In-Person Verbal Comments.** Individuals attending the Board meeting in person may provide a verbal public comment during the Call to the Public agenda item.
    - A person who wishes to provide a verbal public comment in-person must complete and submit a request to speak form available at https://www.azdps.gov/form/somb-call-to-the-public-inperson to Board staff prior to the start of the meeting. The request to speak form informs Board staff that you will be present in person at the meeting to provide your public comment.
    - The Board asks that request to speak forms be completed and submitted prior to the day of the meeting. The form, however, will also be available to complete and submit to Board staff at the meeting. Individuals who submit a request to speak form after the start of the meeting will not be provided the opportunity to speak.
    - Staff will not switch your registration to virtual if you fail to attend the meeting in person.

All Public Comments

- All Board policies in regard to public comment at in-person meetings are transferable to virtual verbal public comment for meetings.
- Both virtual and in-person verbal public comment will be limited to three minutes by the Board Chair, unless the time limit is adjusted by the Board Chair, at the start of the meeting.
- If submitting a request to speak form, Board staff will call on you to speak during the Call to the Public agenda item. Board staff will only call speakers one time. If a speaker is not ready and available to comment at that time, staff will move on to the next speaker. If you miss your turn, Board staff will attempt again at the end of the list. The order in which names are called will be in the order in which the registrations are received.
- Before beginning your public comment, please state your name and organization (if applicable) for the record.
- If you need assistance with submitting a request to speak form, submitting a written public comment or registering for an in-person or virtual public comment, please contact the Board's office at (602) 223-2611 and a staff member will assist you.

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
Monday, April 20, 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. **CALL TO THE PUBLIC —** This is the time for the public to comment. Members of the Board may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism, or scheduling the matter for further consideration and decision at a later date.

    a. Review of Written Public Comments Received
    b. Other Public Comments

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

    a. Statement from Chairwoman Goulden – Sexual Assault Awareness Month and Crime Victims' Rights Week
    b. New Board Member Introductions
    c. Old Business
        1. Letters of Board's Position on SB1240, SB1239, and SB1092
        2. Status of:
            i. HB2870
            ii. HB2966
            iii. SB1829
            iv. SB1240
            v. SB1239
            vi. SB1092

3. Update on By Laws V4 (03.17.2026)
4. Validation Study of the Current Community Notification Assessment
5. Establishing a Request To Speak (RTS) Account with the Arizona Legislature for the AZSOMB

d. Discussion of Call To The Public When They Are Not Respectful of Their Time Limits
e. Pending Legislation: SB1709
f. Presentation from Staff – Working Groups Overview and Proposed Procedure for the Establishment of Working Groups
g. Overview of Board Objectives and Proposed Working Groups
h. Discussion of Documentation on Juvenile Court Practices for Juveniles with Sexually Abusive Behaviors (JSAB)
i. Subcommittee Reports
j. Survivors of Sexual Offenses Presentation by Ms. Missy Musick
k. Call for Future Agenda Items (Deadline May 13, 2026 @ Noon)

4. THE BOARD 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.)

5. ADJOURNMENT

NEXT MEETING:

Arizona Sex Offender Management Board
May 18, 2026 1:30 p.m. – 5 p.m.
Arizona State Capitol
Second Floor Conference Room
1700 West Washington Street
Phoenix, Arizona 85007

BACKGROUND MATERIAL

April 20, 2026

BACKGROUND MATERIAL

April 20, 2026

LETTERS TO LEGISLATURE

OF

BOARD'S POSITION ON

SB1240

SB1239

SB1092

Arizona Sex Offender Management Board
2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 26, 2026

The Honorable Warren Petersen
President of the Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

Dear President Petersen,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

The recording of the meeting is available at: azdps.gov/sites/default/files/2026-03/AZSOMB_March_Meeting-20260323Meeting.mp3) (timestamp discussion begins at 47:05 and concludes at 1:39:30).

The AZSOMB remains committed to working collaboratively with the Executive Branch and the Legislature to advance sound policy. Thank you for your time and consideration.

Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
The Honorable Quang H. Nguyen
The Honorable Analise Ortiz
The Honorable Alma Hernandez

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March 26, 2026

The Honorable Steve Montenegro
Speaker of the Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear Speaker Montenegro,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
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- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
The Honorable Quang H. Nguyen
The Honorable Analise Ortiz
The Honorable Alma Hernandez

Arizona Sex Offender Management Board

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March 26, 2026

The Honorable Katie Hobbs
Governor of Arizona
1700 West Washington Street
Phoenix, Arizona 85007

Dear Governor Hobbs,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

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  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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cc: The Honorable Warren Petersen
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March 26, 2026

The Honorable Oscar De Los Santos
Minority Leader of the Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear Representative De Los Santos,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
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Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Priya Sundareshan
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The Honorable Quang H. Nguyen
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The Honorable Alma Hernandez

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March 26, 2026

The Honorable Priya Sundareshan
Minority Leader of the Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

Dear Senator Sundareshan,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
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The Honorable Wendy Rogers
The Honorable Quang H. Nguyen
The Honorable Analise Ortiz
The Honorable Alma Hernandez

Arizona Sex Offender Management Board

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March 26, 2026

The Honorable Alma Hernandez
Arizona House of Representatives Judiciary Committee
1700 West Washington Street
Phoenix, Arizona 85007

Dear Representative Alma Hernandez,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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Sincerely,

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Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
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The Honorable Analise Ortiz

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March 26, 2026

The Honorable Analise Ortiz
Arizona State Senate Judiciary Committee
1700 West Washington Street
Phoenix, Arizona 85007

Dear Senator Ortiz,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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Sincerely,

Beth Goulden
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Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
The Honorable Quang H. Nguyen
The Honorable Alma Hernandez

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March 26, 2026

The Honorable Wendy Rogers
Arizona State Senate Judiciary Committee
1700 West Washington Street
Phoenix, Arizona 85007

Dear Senator Rogers,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

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Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
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The Honorable Quang H. Nguyen
The Honorable Analise Ortiz
The Honorable Alma Hernandez

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March 26, 2026

The Honorable Quang H. Nguyen
Arizona House of Representatives Judiciary Committee
1700 West Washington Street
Phoenix, Arizona 85007

Dear Representative Quang H. Nguyen,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

The recording of the meeting is available at: azdps.gov/sites/default/files/2026-03/AZSOMB_March_Meeting-20260323Meeting.mp3) (timestamp discussion begins at 47:05 and concludes at 1:39:30).

The AZSOMB remains committed to working collaboratively with the Executive Branch and the Legislature to advance sound policy. Thank you for your time and consideration.

Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
The Honorable Analise Ortiz
The Honorable Alma Hernandez

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 30, 2026

The Honorable Janae Shamp
Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

Dear Senator Shamp,

On behalf of the Arizona Sex Offender Management Board, I write to respectfully express the Board's position on three specific pending pieces of legislation: SB1240, SB1239 and SB1092.

Following review and discussion, the Board voted on March 23, 2026, to:

- **Support - SB1240**
  By a vote of 12 yes, zero no, and eight abstaining, the Board supports this bill as it represents a step in the right direction to stop incentive payments. Additionally, the Board believes that providing incentives to high-risk populations could inadvertently encourage behaviors or conditions the policy is intended to mitigate.

- **Oppose - SB1239**
  By a vote of 13 yes, six no, and one abstaining, the Board opposes the bill as written because it is too broad and it creates a strict liability crime by taking away autonomy of the people who it charges. Additionally, *State v. Helmer,* 203 Ariz. 309 (2002) holds that failing to register is a continuing offense. As long as the sex offender continues to not register, the defendant continues to violate the law, and the statute of limitations is not an issue.

- **Oppose - SB1092**
  By a vote of 16 yes, one no, and three abstaining, the Board opposes the bill as it removes judicial discretion in instances such as those involving the aging population, persons with developmental disabilities, and situations related to youth and young adults.

The recording of the meeting is available at: azdps.gov/sites/default/files/2026-03/AZSOMB_March_Meeting-20260323Meeting.mp3) (timestamp discussion begins at 47:05 and concludes at 1:39:30).

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Sincerely,

Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan
The Honorable Wendy Rogers
The Honorable Quang H. Nguyen
The Honorable Analise Ortiz
The Honorable Alma Hernandez

BACKGROUND MATERIAL

April 20, 2026

LETTERS TO THE LEGISLATURE

ON

DOCUMENTS SENT BY

MEMBERS OF THE PUBLIC

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 26, 2026

The Honorable Steve Montenegro
Speaker of the Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear Speaker Montenegro,

We were recently made aware of a document submitted to the Arizona Legislature by members of the public that appeared to be authored by the Arizona Sex Offender Management Board (AZSOMB). It was unequivocally not authored by us.

Please be advised that any official communication from the AZSOMB will be on this letterhead and signed by the Chair Beth Goulden. Please do not hesitate to reach out to AZSOMB staff at AZSOMB@AZDPS.GOV if you have any questions regarding the authenticity of a communication you may have received.

Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 26, 2026

The Honorable Warren Petersen
President of the Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

Dear President Petersen,

We were recently made aware of a document submitted to the Arizona Legislature by members of the public that appeared to be authored by the Arizona Sex Offender Management Board (AZSOMB). It was unequivocally not authored by us.

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Sincerely,

Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan

Arizona Sex Offender Management Board

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Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 26, 2026

The Honorable Katie Hobbs
Governor of Arizona
1700 West Washington Street
Phoenix, Arizona 85007

Dear Governor Hobbs,

We were recently made aware of a document submitted to the Arizona Legislature by members of the public that appeared to be authored by the Arizona Sex Offender Management Board (AZSOMB). It was unequivocally not authored by us.

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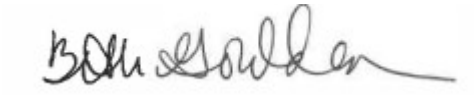
Sincerely,



Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Steve Montenegro
The Honorable Warren Petersen
The Honorable Oscar De Los Santos
The Honorable Priya Sundareshan

Arizona Sex Offender Management Board

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Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 26, 2026

The Honorable Oscar De Los Santos
Minority Leader of the Arizona House of Representatives
1700 West Washington Street
Phoenix, Arizona 85007

Dear Representative De Los Santos,

We were recently made aware of a document submitted to the Arizona Legislature by members of the public that appeared to be authored by the Arizona Sex Offender Management Board (AZSOMB). It was unequivocally not authored by us.

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Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable Warren Petersen
The Honorable Steve Montenegro
The Honorable Priya Sundareshan

Arizona Sex Offender Management Board

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March 26, 2026

The Honorable Priya Sundareshan
Minority Leader of the Arizona State Senate
1700 West Washington Street
Phoenix, Arizona 85007

Dear Senator Sundareshan,

We were recently made aware of a document submitted to the Arizona Legislature by members of the public that appeared to be authored by the Arizona Sex Offender Management Board (AZSOMB). It was unequivocally not authored by us.

Please be advised that any official communication from the AZSOMB will be on this letterhead and signed by the Chair Beth Goulden. Please do not hesitate to reach out to AZSOMB staff at AZSOMB@AZDPS.GOV if you have any questions regarding the authenticity of a communication you may have received.

Sincerely,

Beth Goulden
Chairperson
Arizona Sex Offender Management Board

cc: The Honorable Katie Hobbs
The Honorable. Warren Petersen
The Honorable Steve Montenegro
The Honorable Oscar De Los Santos

BACKGROUND MATERIAL

April 20, 2026

LETTERS TO

THREE MOMS

ON

DOCUMENTS SENT TO LEGISLATURE

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 30, 2026

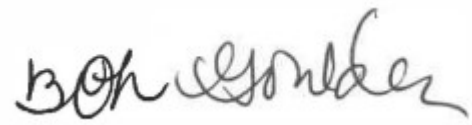
Rachel Bretz
Three Moms
[redacted]

Dear Rachel Bretz,

We are aware of a folder you distributed to the Arizona Legislature on or about March 9, 2026. One of the flyers in your folder incorrectly appeared to be authored by the Arizona Sex Offender Management Board ("AZSOMB"), and some lawmakers believed that it was. We had to explain repeatedly that the flyer was not authored by the AZSOMB and that we had no part in creating it. Please be advised if you create and present a document that misleads the Legislature into believing it came from the AZSOMB, it could constitute a violation of law.

You are of course free to advocate for yourself and others. However, you should not purport to speak on behalf of the AZSOMB.

Sincerely,



Chairperson
Arizona Sex Offender Management Board

Enclosure

cc: Kim Drogosz
Stephanie Sutton
Jennifer Hammer

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 31, 2026

Kim Drogosz
Three Moms
[redacted]

Dear Kim Drogosz,

We are aware of a folder you distributed to the Arizona Legislature on or about March 9, 2026. One of the flyers in your folder incorrectly appeared to be authored by the Arizona Sex Offender Management Board ("AZSOMB"), and some lawmakers believed that it was. We had to explain repeatedly that the flyer was not authored by the AZSOMB and that we had no part in creating it. Please be advised if you create and present a document that misleads the Legislature into believing it came from the AZSOMB, it could constitute a violation of law.

You are of course free to advocate for yourself and others. However, you should not purport to speak on behalf of the AZSOMB.

Sincerely,

Chairperson
Arizona Sex Offender Management Board

Enclosure

cc: Stephanie Sutton
Rachel Bretz
Jennifer Hammer

Arizona Sex Offender Management Board

2222 West Encanto Boulevard | Phoenix, Arizona 85009
Home Page: https://www.azdps.gov/sex-offender-management-board
Telephone (602) 223-2611 | Email AZSOMB@AZDPS.GOV

March 31, 2026

Jennifer Hammer
Three Moms
[redacted]

Dear Jennifer Hammer,

We are aware of a folder you distributed to the Arizona Legislature on or about March 9, 2026. One of the flyers in your folder incorrectly appeared to be authored by the Arizona Sex Offender Management Board ("AZSOMB"), and some lawmakers believed that it was. We had to explain repeatedly that the flyer was not authored by the AZSOMB and that we had no part in creating it. Please be advised if you create and present a document that misleads the Legislature into believing it came from the AZSOMB, it could constitute a violation of law.

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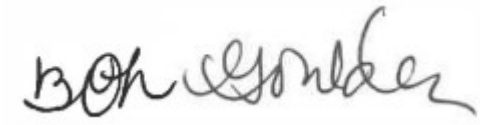

Chairperson
Arizona Sex Offender Management Board

Enclosure

cc: Kim Drogosz
Stephanie Sutton
Rachel Bretz

Arizona Sex Offender Management Board

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March 31, 2026

Stephanie Sutton
Three Moms
[redacted]

Dear Stephanie Sutton,

We are aware of a folder you distributed to the Arizona Legislature on or about March 9, 2026. One of the flyers in your folder incorrectly appeared to be authored by the Arizona Sex Offender Management Board ("AZSOMB"), and some lawmakers believed that it was. We had to explain repeatedly that the flyer was not authored by the AZSOMB and that we had no part in creating it. Please be advised if you create and present a document that misleads the Legislature into believing it came from the AZSOMB, it could constitute a violation of law.

You are of course free to advocate for yourself and others. However, you should not purport to speak on behalf of the AZSOMB.

Sincerely,

Chairperson
Arizona Sex Offender Management Board

Enclosure

cc: Kim Drogosz
Rachel Bretz
Jennifer Hammer

Three Moms:
Their Legal Reality

SOMB OPPOSES:

HB2870, HB2966(SB1092), SB1829

SOMB= Sex Offender Management Board

Three Moms Bringing Attention to:

Dangerous Crimes Against Children (DCAC) Misconceptions and the Impacts of Sex Offender Housing Restrictions

---

The materials in this packet are provided to explain the Dangerous Crimes Against Children (DCAC) designation and how it applies not only to violent hands-on offenses but also to non-contact, non-dangerous, non-repetitive access of illegal digital images.

These materials also include how the proposed housing restrictions could create unintended consequences for sex offenders who are already struggling to secure stable housing, as well as an explanation of why the proposed amendments would not resolve the underlying problem.

Packet Contents

1. **Policy Concerns Regarding Proposed Legislation**

2. **Dangerous Crimes Against Children (DCAC) Statute and Application**
   a) Understanding A.R.S. § 13-705
   b) Relevant Sections of the Statute
   c) History and Technological Context

3. **Constituent Stories**
   a) Kim Drogosz – Autism and online content access
   b) Stephanie Sutton – Online grooming of a vulnerable minor
   c) Rachel Bretz – Young adult, mental health and digital content exposure
   d) Jennifer Hammer – Successful shared housing in jeopardy

4. **Why the Amendment to SB2870 Does Not Resolve the Problem of Additional Housing Restrictions – and Why the Sex Offender Management Board OPPOSES it**

5. **Explanation Sheet: Autism and Public Systems**

Arizona Sex Offender Management Board

Opposes Three Legislative Bills

OFFICIAL POSITION — FEBRUARY 23, 2026 BOARD MEETING

21 Board Members Present

Established by HB 1030, signed June 2024

Governor Katie Hobbs

AZ Dept. of Public Safety

The Arizona Sex Offender Management Board — a multidisciplinary, state-authorized body comprising law enforcement, judiciary, corrections, victim advocates, mental health professionals, and community representatives — **voted to officially oppose all three bills listed below.** These votes reflect the board's evidence-based mission to enhance community safety and reduce recidivism. The SOMB respectfully urges the legislature to pause and allow the board to complete its ongoing, evidence-based policy recommendations before these measures are advanced.

SB 2870

Residence of Sex Offenders; Regulation

Severely restricts the ability of registered sex offenders to live in shared housing arrangements statewide.

SOMB VOTE TO OPPOSE

19 Yes · 0 No · 2 Abstain

BOARD MEMBER TESTIMONY

"Stable housing is directly related to recidivism risk. This bill represents a significant reduction in viable housing options."
— **Board Member, Sex Offender Supervision Professional**

"Supervising officers already approve or deny residence on a case-by-case basis daily. Healthy individuals doing well in treatment often support one another — that flexibility should remain local, not overridden by statewide mandate."
— **Board Member, Probation/Supervision Professional**

"This does not benefit public safety, nor does it speak to rehabilitation. It fails to account for group homes, pathway houses, and assisted living facilities for aging and medically vulnerable populations."
— **Board Member, Public Defender / Legal Professional**

"If this was born from a problem in a specific city, it can and should be handled at the local level — through zoning or local ordinance — not statewide legislation."
— **Board Member**

HB 2966

Dangerous Crimes Against Children; Probation

Eliminates the ability of individuals with a DCAC designation to petition for early termination of probation.

SOMB VOTE TO OPPOSE

18 Yes · 0 No · 3 Abstain

BOARD MEMBER TESTIMONY

"DCAC is a legal sentencing enhancement — not a clinical risk instrument. It does not capture who the most dangerous individuals are. Basing supervision policy on a single legal label does not make the community safer."
— **Board Member, Mental Health / Clinical Professional**

"The ability to petition for early termination is a meaningful incentive for treatment engagement. Eliminating hope increases frustration and disengagement — outcomes that raise, not lower, risk."
— **Board Member, Treatment Professional**

"Individuals routinely have early termination petitions denied. This is not a rubber stamp — it is a rigorous, judge-overseen process. Eliminating judicial discretion, including for elderly or medically incapacitated individuals, is not sound policy."
— **Board Chairwoman, 25 Years in Sex Offender Supervision**

SB 1679

Probation; Dangerous Crimes Against Children

Mirror bill to HB 2966, excluding minors. Carries the same structural concerns regarding evidence-based supervision.

SOMB VOTE TO OPPOSE

16 Yes · 1 No · 4 Abstain

BOARD MEMBER TESTIMONY

"There are cases involving young adults — 18 or 19 — where circumstances are complex. Mandating lifetime supervision regardless of risk trajectory, treatment progress, or changed circumstances is not evidence-based policy."
— **Board Member, Probation / Supervision Professional**

"Risk-need-responsivity requires supervising the highest-risk individuals most intensively. These bills replace risk-based logic with offense-based categories — a step backward in public safety science."
— **Board Member, Clinical / Treatment Professional**

"Defense attorneys advise clients to accept plea deals based on the understanding that they can petition after seven years. Eliminating that option retroactively undermines the integrity of the plea process."
— **Board Member, Legal Professional**

"Public safety resources are finite. We should direct intensive supervision toward individuals who present measurable, ongoing risk — not adopt blanket policies that make no distinction between levels of danger."
— Board Chairwoman

"As a board, it is our duty to provide logic alongside the emotion that drives legislation. Both matter — but policy must be grounded in evidence."
— Board Member

About the Sex Offender Management Board

Established by Arizona SB 1630, signed into law June 21, 2024 by Governor Hobbs, the SOMB operates within the Department of Public Safety. Its mission is to enhance community safety through research-driven standards that reduce recidivism and prioritize victim protection. The board uses the risk-need-responsivity model and other evidence-based correctional frameworks to develop statewide policy recommendations.

Board Membership Includes

- Judicial officers
- Law enforcement and corrections professionals
- Licensed mental health and treatment experts
- Victim advocates
- Probation and supervision officers
- Legal professionals (prosecution and defense)
- Education and community representation
- Representatives from both urban and rural Arizona

Source: Official SOMB Meeting Transcript, February 23, 2026 | **azdps.gov/sex-offender-management-board** | This document prepared for legislative outreach purposes.

Why the Amendment to SB2870 Does Not Resolve the Problem of Additional Housing Restrictions — and Why the Sex Offender Management Board Opposes It

Summary
As amended, SB2870 prohibits Level 2 and Level 3 registrants from residing together in a single-family dwelling, with limited exceptions for legally related individuals, certain pre-2026 community reentry centers, and certified behavioral health residential facilities. In practice, most shared housing arrangements for registrants do not qualify for these narrow exemptions. The bill would significantly reduce lawful housing options for individuals on probation or community supervision without creating additional treatment or supervision infrastructure. Stable housing is a foundational component of compliance and risk management. For these reasons, we respectfully ask you not to advance SB2870.

---

1. The Amendment Creates a Blanket Co-Residency Ban
The amended bill makes it unlawful for a Level 2 or Level 3 registrant who is on probation or community supervision to reside in a single-family dwelling with another registrant.

The only exceptions are:

- Individuals legally related by blood, marriage, or adoption
- A state-operated community reentry center that began on or before January 1, 2026
- A certified behavioral health residential facility subject to DHS oversight that commenced operation on or before January 1, 2026

---

2. Most Shared Registrant Housing Does Not Qualify for These Exceptions
The majority of shared housing arrangements in Arizona:

- Are ordinary rental homes
- Are not state-operated community reentry centers
- Are not certified behavioral health residential facilities
- Do not operate as licensed residential treatment programs

Residents attend required treatment and supervision **off-site** through probation departments and licensed providers. The residence itself is not a treatment facility. As drafted, the bill would eliminate most shared housing arrangements currently used by compliant individuals under supervision.

---

3. The "Facility" Exceptions Are Extremely Narrow
The amendment exempts:

- Community reentry centers operated by the Department of Corrections that began operation on or before January 1, 2026
- Certified behavioral health residential facilities that commenced operation on or before January 1, 2026

This language:

- Freezes eligibility to existing facilities
- Prevents new facilities from qualifying
- Does not apply to ordinary shared housing
- Does not address cost-sharing living arrangements

In practice, very few registrants reside in state-operated reentry centers or licensed behavioral health residential facilities.

---

4. Practical Public Safety Implications

Reducing lawful housing options for individuals on probation or community supervision may result in:

- Increased housing instability
- Higher financial barriers to compliance
- Greater risk of homelessness
- Harder supervision logistics
- Movement into less stable or less visible housing arrangements

Stable housing is directly tied to supervision compliance, treatment participation, and monitoring effectiveness.

---

5. Existing Supervision Tools Already Address Risk

Probation departments already have authority to:

- Impose individualized housing conditions
- Restrict co-residency on a case-by-case basis
- Increase supervision where concerns arise
- Conduct inspections and compliance checks

If a particular living arrangement presents a supervision or safety concern, probation officers can address it directly through individualized conditions rather than through a blanket statutory prohibition.

Importantly, the Arizona Sex Offender Management Board (SOMB) has emphasized that supervision and management tools should be applied locally and individually rather than through broad categorical housing restrictions and voted to OPPOSE this bill!

Conclusion

The amended version of SB2870 imposes a categorical co-residency ban that will significantly reduce lawful housing options for supervised individuals without expanding treatment capacity or supervision infrastructure. The narrow facility exemptions do not reflect how most registrant housing operates in practice. For these reasons, we respectfully ask you not to advance SB2870.

BACKGROUND MATERIAL

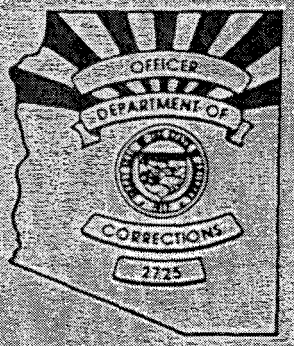
April 20, 2026

SEX OFFENDER RISK ASSESSMENT VALIDATION STUDY

PROVIDED BY

CHAIRWOMAN BETH GOULDEN

ARIZONA DEPARTMENT OF CORRECTIONS



SEX OFFENDER RISK ASSESSMENT VALIDATION STUDY

TERRY L. STEWART
Director

RICHARD G. CARLSON
Deputy Director
Administration

MEG SAVAGE
Assistant Director
Human Resources/Development

August 1, 2000

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EXECUTIVE SUMMARY

The purpose of this report is to present the findings of the current validation study of the Arizona Sex Offender Assessment Screening Profile for Regulatory Community Notification, known hereafter as the Risk Assessment. This instrument was implemented as part of the Community Notification Law, ARS 13-3825, effective June 1996. The Risk Assessment classifies sex offenders who have been released from Arizona prisons or who were placed on probation (after June 1996), into three categories of risk for recidivism. In turn, the assigned categories describe the level of notification and manner in which the community is told by law enforcement of the offender's release from prison, or placement on probation, through notification guidelines. The Risk Assessment was initially adapted from an instrument previously used in Minnesota for similar community notification purposes.

In August 1998, a study was undertaken to determine the validity of the instrument. This study examined all sex offenders released from prison or placed on probation in Arizona between June 1, 1996 and June 30, 1998. Because of the proximity to the date of implementation of the Sex Offender Notification law in Arizona, the follow-up period involved in the study was not of sufficient length to allow a true validation of the instrument as a predictor of future sex offending and/or long term recidivism. With this in mind, and in an attempt to determine whether sex offenders subject to the notification law simply left Arizona to avoid notification (and then committed crimes in other states), an expanded validation study using national-level follow-up data was undertaken.

Specifically, ADC requested records from the Federal Bureau of Investigation (FBI) on Arizona sex offenders released from prison between July 1, 1983 and June 30, 1998. This included offenders from the 1998 study, as well as previously released sex offenders who are being studied as part of a parallel effort to determine longer-term patterns of sex offender recidivism in Arizona. Unfortunately, because of a lack of identifying information, sex offenders in the original study who were released on probation were not included in the second phase of the study. However, the expanded study did include a comparison group of offenders who were released subject to sex offender registration requirements but without community notification. Due to a higher concentration of repeat offenders, the "registration-only" cases, which include offenders with prior but not current sex offenses, recorded higher rates of general recidivism but lower rates of sex offense recidivism than did the notification cases. As indicated by the results of the current study, many of the offenders in the notification group are first-time-only sex offenders who pose a greater risk of sexual re-offending but a much lower risk of re-offending in some other manner.

- **The results of the 1998 study demonstrated that the instrument being used in Arizona for community notification was valid as a predictor of recidivism.** In the 1998 study, the percentage of released sex offenders returned to prison in Arizona increased from 2.8% for Level I offenders, the lowest risk group, to 7.5% for Level II offenders, an intermediate risk group, to 15.5% for Level III offenders, the highest risk group.

- **The results of the expanded validation study, which included the FBI follow-up data, provided much more extensive and conclusive confirmation of the validity of the instrument for the prediction of recidivism. In addition, the expanded study documented the validity of the instrument as a predictor of sex offense recidivism.** In the expanded study, the general recidivism rate (re-arrest for a violent, sex, or felony offense) increased from 5.3% for Level I offenders, to 23.2% for Level II offenders, to 48.3% for Level III offenders. Additionally, the sex offense re-arrest rate was determined to be 3.5% for Level I offenders, 3.6% for Level II offenders, and 12.7% for Level III offenders.

- **While the current instrument has been thoroughly validated for the prediction of both general and sex offense recidivism, the results of the updated study do indicate that improvements to the instrument are possible. Consequently, a revised instrument, with improved predictive validity, was developed for consideration by the Community Notification Guidelines Committee.** Based on the results of the preliminary study, a few relatively minor modifications to the original instrument were recommended. However, since the FBI data request was pending, it was decided to wait until the final validation results were available before recommending any modification to the Risk Assessment. Based on the most recent validation data, it appears that the Risk Assessment, with some modification, can become an even stronger predictor of both general and sex offense recidivism. The proposed modifications include 1) eliminating factors that have proven to be poor predictors of recidivism, 2) adjusting weights on individual factors to improve predictive validity, and 3) modifying the scoring scale for the instrument. One of the weaknesses of the Risk Assessment is the relatively high percentage of cases (71.3%) assigned to the intermediate risk level (Level II). The proposed modifications would reduce this percentage to 54.4% and would correspondingly increase the percentages of cases assigned to Level I (9.3% to 17.3%) and Level III (19.4% to 28.3%).

INTRODUCTION

The purpose of this report is to present the findings of the current validation study of the Arizona Sex Offender Assessment Screening Profile for Regulatory Community Notification, hereafter referred to as the Risk Assessment. This instrument, which was implemented as part of the Community Notification Law in June of 1996, classifies released sex offenders in Arizona into three levels of risk for recidivism. In turn, the assigned risk levels are instrumental in determining the manner in which the community is notified of the offender's release. The Risk Assessment was adapted from a similar instrument previously in use in the state of Minnesota.

The screening instrument scores sex offenders on 19 separate "risk factors" as follows:

- ✓ Number of Convictions for Sex/Sex-Related Offenses (1, 4, or 6 points)
- ✓ Number of Convictions for (Non-Sex) Felony Offenses (0, 2, or 6 points)
- ✓ Other Sex/Sex-Related Arrests Not Resulting in Conviction (0 or 4 points)
- ✓ Age at First Conviction for Sex/Sex-Related Offense (0 or 3 points)
- ✓ Use of Weapon in Sex/Sex-Related Convictions (0, 4, or 6 points)
- ✓ Total Number of Victims in All Sex Offenses (0, 1, 4, or 6 points)
- ✓ Gender of Victims in All Sex Offense Convictions (0, 2, or 4 points)
- ✓ Relationship of Offender to Victim (0, 2, or 4 points)
- ✓ Use of Force (0 or 6 points)
- ✓ Other Characteristics of Sex/Sex-Related Convictions (0 or 4 points)
- ✓ Length of Sex Offense History (0 or 4 points)
- ✓ Alcohol/Drug Usage (0 or 3 points)
- ✓ Mental/Cognitive Impairment of Offender (0 or 4 points)
- ✓ Employment History (0 or 3 points)
- ✓ Presence of Multiple Paraphilias/Sexually Deviant Interests (0, 2, or 4 points)
- ✓ Felony Committed Upon Previous Release from Confinement (0, 2, 4, 6, or 8 points)
- ✓ Discipline History While in Prison (0 or 6 points)
- ✓ Chemical Dependency Treatment While in Prison (0 or 4 points)
- ✓ Sex Offender Treatment While in Prison or On Probation (0, 2, or 5 points)

Each released sex offender is assigned a score on each of the 19 risk factors, and a total risk score is computed to reflect the offender's overall level of risk. A *Risk/Notification Level* is then assigned based on the total score as follows:

LEVEL I (*Lower Risk*; Lowest Notification Requirements) 0-14
LEVEL II (*Intermediate Risk*; Moderate Notification Requirements) 15-39
LEVEL III (*High Risk*; Highest Notification Requirements) . . . . . 40 or Above

A preliminary validation study of the Risk Assessment was conducted by Arizona Department of Corrections (ADC) research staff in July of 1998. The results indicated an acceptable level of validity in predicting future admissions to the department. Specifically, based on a coefficient referred to as the Mean Cost Rating (MCR), the correlation between risk level and return to ADC custody came to 0.292.

Because of the recency of implementation of the Sex Offender Notification Program in Arizona, the follow-up period involved in the original study was not of sufficient length (an average of 12 months) to allow a validation of the instrument as a predictor of future sex offending or of long-term recidivism. Due to this limitation, the decision was made to conduct a more definitive study of instrument validity. To provide the most comprehensive follow-up information possible, a request was made to the Federal Bureau of Investigation (FBI) for record checks on released Arizona sex offenders. This request included all sex offenders released from the Arizona Department of Corrections over the period from July 1, 1983 through June 30, 1998, and included all ADC sex offenders represented in the original study. Unfortunately, because of the lack of identifying information (SID and FBI Numbers), sex offenders from the original study who were released on probation (as opposed to being released from prison) were not included in the request to the FBI.

It should be noted that the request to the FBI included sex offenders being examined by ADC research staff as part of a longer-term study of sex offender recidivism in Arizona. This study, which has targeted over 3,000 sex offenders released to the streets over a 15-year period, will provide definitive information on general and sex offense recidivism rates among sex offenders released from prison in this state. Eventually, the results of this study may be used to guide further improvements to the sex offender risk assessment process in Arizona.

STUDY PARAMETERS

The present validation study focuses on 614 sex offenders released from the custody of the Arizona Department of Corrections from June 1, 1996 through June 30, 1998. This includes offenders released with or without supervision. These 614 offenders were all released from sentences of incarceration for current sex offenses, and accordingly were eligible to be included in the *Arizona Sex Offender Notification Program*. An additional 212 released offenders included in the study had previous sex offenses on their records which required them to submit to sex offender registration in Arizona. These 212 offenders were not subject to community notification laws and were not assigned sex offender risk levels. They were included in the current study only for the purpose of comparing their follow-up results with those for the notification group. Accordingly, the majority of the report concerns the notification group only.

All 826 offenders in the present study were followed to April 30, 2000 for possible re-admission to the Arizona Department of Corrections. This provided an average (mean) follow-up period of 34.0 months, including 34.1 months for the 614 notification cases and 33.6 months for the 212 registration-only cases. In addition, all 826 offenders were followed to approximately November 1999 for criminal justice contacts recorded by the Federal Bureau of Investigation. FBI data provided information on rearrests, reconvictions, and prison admissions in jurisdictions other than the state of Arizona. The FBI portion of the follow-up averages approximately 28.5 months.

For purposes of the present validation study, nine (9) separate indicators of recidivism are considered. They are as follows:

- ✓ Rearrest (Any Offense) or Return to Prison (Technical Violation or New Offense)

- ✓ Rearrest (Any Offense)
- ✓ Rearrest (Violent, Sex, or Felony Offense)
- ✓ Rearrest (Violent or Sex Offense)
- ✓ Rearrest (Sex Offense)

- ✓ Reconviction (Any Offense)
- ✓ Reconviction (Violent, Sex, or Felony Offense)

- ✓ Return to Prison (Technical Violation or New Offense)
- ✓ Return to Prison (Felony Conviction)

While results are presented for each of the above recidivism measures, two measures are given special emphasis in the report, and, in fact, are utilized for the purpose of developing suggested improvements to the Risk Assessment. These are Rearrest (Violent, Sex, or Felony Offense), referred to as General Recidivism, and Rearrest (Sex Offense), referred to as Sex Offense Recidivism.

RISK ASSESSMENT VALIDATION

As outlined on the previous page, the Risk Assessment provides for three levels of offender risk, ranging from Level I (Lower Risk), to Level II (Intermediate Risk), to Level III (High Risk). The presumption is that the higher the risk level of the sex offender, the greater the chances are that the offender will recidivate. The following tabulation indicates how the total population of 614 released sex offenders breaks out among the three risk levels:

- ✓ 57 cases (9.3%) were classified as ***Level I*** (Lower Risk)
- ✓ 438 cases (71.3%) were classified as ***Level II*** (Intermediate Risk)
- ✓ 119 cases (19.4%) were classified as ***Level III*** (High Risk)

To validate the Risk Assessment, it is necessary to compare follow-up results across risk levels. This is accomplished with the information presented below (see also the chart on page 7). Follow-up results are broken out by risk level for each of nine (9) separate measures of recidivism. In addition, a correlation coefficient (Mean Cost Rating or MCR) is indicated which gauges the ability of the instrument to predict that type of recidivism. Correlation coefficients logically vary from 0.00 (no predictive or random predictive ability) to 1.00 (perfect predictive ability). The results are as follows:

✓ Increasing risk correlates with an increasing frequency of ***rearrest or return to prison***:

Level I	7.0%
Level II	35.4%
Level III	59.7%

Correlation Coefficient (MCR) = 0.264

✓ Increasing risk correlates with an increasing frequency of ***rearrest for any offense***:

Level I	5.3%
Level II	28.5%
Level III	52.9%

Correlation Coefficient (MCR) = 0.269

✓ Increasing risk correlates with an increasing frequency of ***rearrest for a violent, sex, or felony offense***:

Level I	5.3%
Level II	23.3%
Level III	47.9%

Correlation Coefficient (MCR) = 0.276

Note: Violent offenses include homicide, kidnapping, aggravated assault, robbery, weapons offenses, child abuse, and arson of an occupied dwelling.

✓ Increasing risk correlates with an increasing frequency of ***rearrest for a violent or sex offense***:

Level I 3.5%
Level II 9.6%
Level III 26.9%

Correlation Coefficient (MCR) = 0.296

✓ Increasing risk correlates with an increasing frequency of ***rearrest for a sex offense***:

Level I 3.5%
Level II 3.7%
Level III 12.6%

Correlation Coefficient (MCR) = 0.277

✓ Increasing risk correlates with an increasing frequency of ***reconviction for any offense***:

Level I 3.5%
Level II 11.2%
Level III 24.4%

Correlation Coefficient (MCR) = 0.239

✓ Increasing risk correlates with an increasing frequency of ***reconviction for a violent, sex, or felony offense***:

Level I 3.5%
Level II 9.6%
Level III 22.7%

Correlation Coefficient (MCR) = 0.250

✓ Increasing risk correlates with an increasing frequency of ***return to prison for any reason (technical violation or new offense)***:

Level I 5.3%
Level II 17.8%
Level III 36.1%

Correlation Coefficient (MCR) = 0.243

✓ Increasing risk correlates with an increasing frequency of ***return to prison with a new felony conviction***:

Level I	3.5%
Level II	7.5%
Level III	21.0%

Correlation Coefficient (MCR) = 0.277

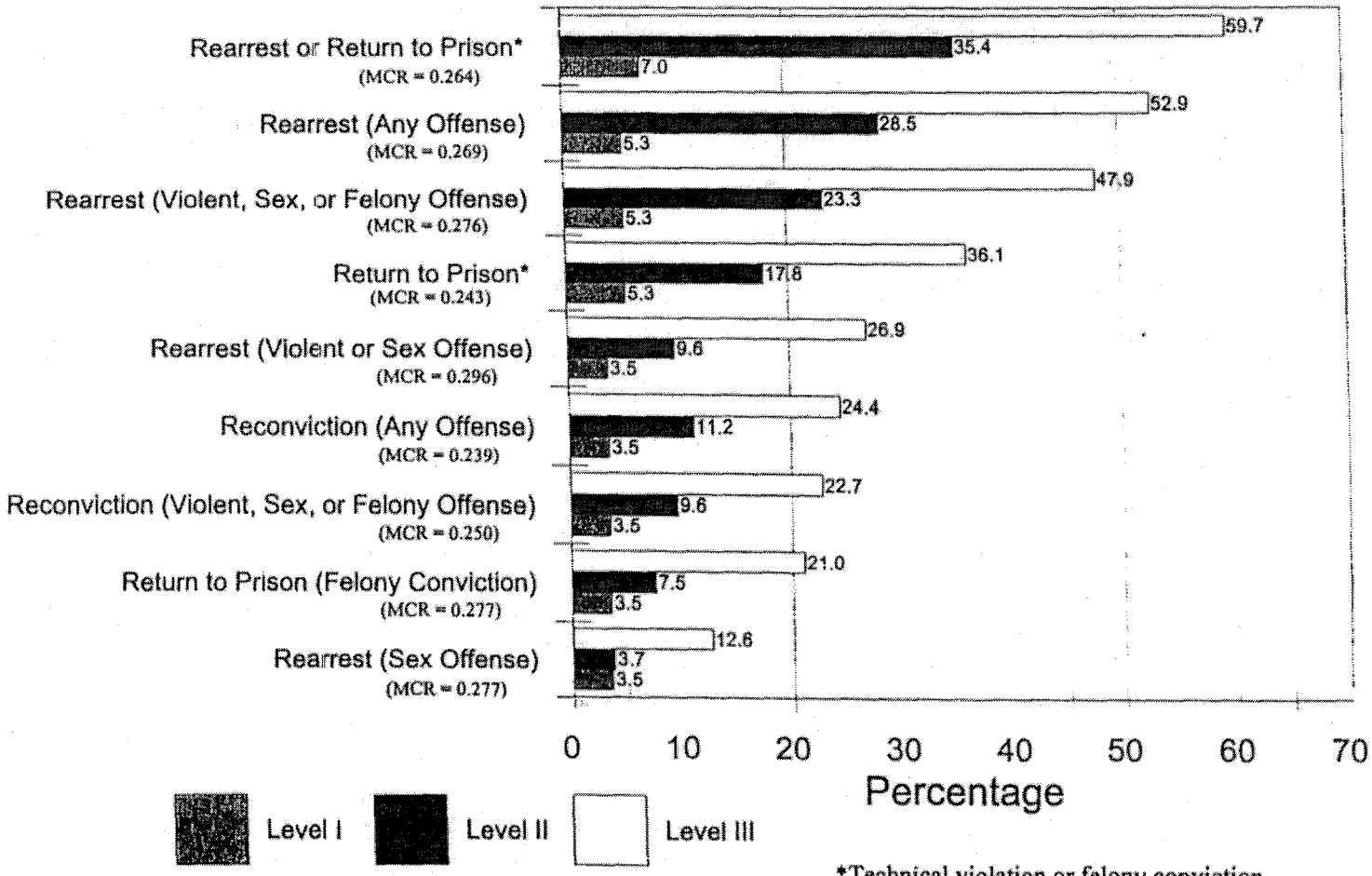
The demonstrated values of the correlation coefficient, although not especially high, are nonetheless high enough to indicate a definite degree of validity of the Risk Assessment as a predictor of general recidivism and of new violent and sex offenses. In most cases, the higher the risk level, the higher the recidivism rate. However, predictive validity is also affected by the numbers of cases falling in individual risk levels. Certainly, the predictive validity of the instrument is somewhat limited by the relatively high percentage of cases (71.3%) assigned to Level II (Intermediate Risk).

The ideal situation in recidivism prediction is that all targeted offenders are classified as either High Risk (predicted to recidivate) or Low Risk (predicted not to recidivate), with the High Risk group recording much higher rates of actual recidivism than the Low Risk group. In practice, however, it is usually necessary to break out an Intermediate Risk group representing offenders for whom a definite pro or con prediction of recidivism is not available or possible. Generally speaking, the larger the Intermediate Risk group, the less efficient the instrument as a predictor of recidivism. The adverse effect of a large Intermediate Risk group may be mitigated, however, if there is a large difference in recidivism rates across risk levels. To a certain extent, this is the case with the current sex offender risk assessment instrument in Arizona.

Note: For information on MCR, please see "Computing Mean Cost Ratings (MCR)" by James A. Inciardi, Dean V. Babst, and Mary Koval in the January 1973 issue (Volume 10, Number 1) of the well-respected Journal of Research in Crime and Delinquency. In this article, the authors note "The literature of the past two decades suggests that it (MCR) represents perhaps the most satisfactory statistical index of predictive selectivity."

RECIDIVISM FOLLOW-UP RESULTS

By Risk/Notification Level



*Technical violation or felony conviction.

RISK FACTOR VALIDATION

In this section of the report, the 19 risk factors which contribute to the Risk Assessment will be examined individually for predictive validity. Clearly, one should expect variation in the performance of individual factors, especially in light of the fact that the Risk Assessment was adapted from a similar instrument in use in another state (Minnesota) without the benefit of independent validation. It is important to know how well individual predictors work in Arizona. With this type of information, adjustments can be made to the Risk Assessment which are likely to result in a significant improvement to the instrument.

In order to keep the volume of information necessary to validate risk factors to a manageable level, consideration is given to two recidivism indicators only, those being *"Rearrest for a Violent, Sex, or Felony Offense,"* and *"Rearrest for a Sex Offense."* These two indicators provide measures of "general recidivism" and "sex offense recidivism," respectively. The decision was made to examine rearrest rather than reconviction data because available follow-up periods were not of sufficient length to allow a significant portion of serious new charges (including sex offenses) to be adjudicated in court.

The bar graphs on pages 11-12 rank order the 19 risk factors according to the magnitude of the correlation (MCR) of each factor with general recidivism and sex offense recidivism. In each case, those factors recording the highest MCR values are those demonstrating the highest degrees of predictive validity.

With regard to either type of recidivism, risk factors may be classified as follows:

1) *Very Good* Predictors
2) *Good* Predictors
3) *Marginal* Predictors
4) *Poor* Predictors
5) *Non*-Predictors.

Very Good Predictors are those with MCR values of +0.200 or greater. Good Predictors are those with MCR values in the range +0.100 to +0.199. Marginal predictors are those with MCR values in the range +0.050 to +0.099. Poor Predictors are those with MCR values in the range +0.000 to +0.049. Finally, Non-Predictors are those with negative MCR values (indicating negative or reverse prediction).

The classification of factors as predictors of ***general recidivism*** is as follows:

Very Good Predictors	MCR
Number of Convictions for Non-Sex-Related Felony Offenses	0.293
Discipline History While in Prison	0.258
Relationship of Offender to Victim	0.219
Felony Committed Upon Previous Release from Incarceration	0.214
Alcohol/Drug Usage	0.200

Good Predictors	MCR
Employment History	0.180
Chemical Dependency Treatment While in Prison	0.164
Age at First Conviction for Sex/Sex-Related Offense	0.151
Use of Force	0.127

Marginal Predictors	MCR
Number of Convictions for Sex/Sex-Related Offenses	0.073
Use of Weapon in Sex/Sex-Related Convictions	0.062

Poor Predictors	MCR
Other Characteristics of Sex/Sex-Related Convictions	0.046
Mental/Cognitive Impairment of Offender	0.044
Sex Offender Treatment While in Prison	0.041
Sex/Sex-Related Arrests Not Resulting in Conviction	0.032
Total Number of Victims in All Sex Offenses	0.024

Non-Predictors	MCR
Length of Sex Offense History	-0.026
Gender of Victims in All Sex Offense Convictions	-0.076
Presence of Multiple Paraphilias/Sexually Deviant Interests	-0.126

The classification of factors as predictors of ***sex offense recidivism*** is as follows:

Very Good Predictors	MCR
Felony Committed Upon Previous Release from Incarceration	0.310
Relationship of Offender to Victim	0.282
Number of Convictions for Non-Sex-Related Felony Offenses	0.282
Number of Convictions for Sex/Sex-Related Offenses	0.236
Use of Weapon in Sex/Sex-Related Convictions	0.236
Total Number of Victims in All Sex Offenses	0.212

Good Predictors	MCR
Sex/Sex-Related Arrests Not Resulting in Conviction	0.180
Employment History	0.162
Length of Sex Offense History	0.149
Chemical Dependency Treatment While in Prison	0.148
Discipline History While in Prison	0.137
Alcohol/Drug Usage	0.126
Mental/Cognitive Impairment of Offender	0.126
Sex Offender Treatment While in Prison	0.109

Poor Predictors	MCR
Use of Force	0.042
Age at First Conviction for Sex/Sex-Related Offense	0.039
Other Characteristics of Sex/Sex-Related Convictions	0.024
Presence of Multiple Paraphilias/Sexually Deviant Interests	0.002

Non-Predictors	MCR
Gender of Victims in All Sex Offense Convictions	-0.018

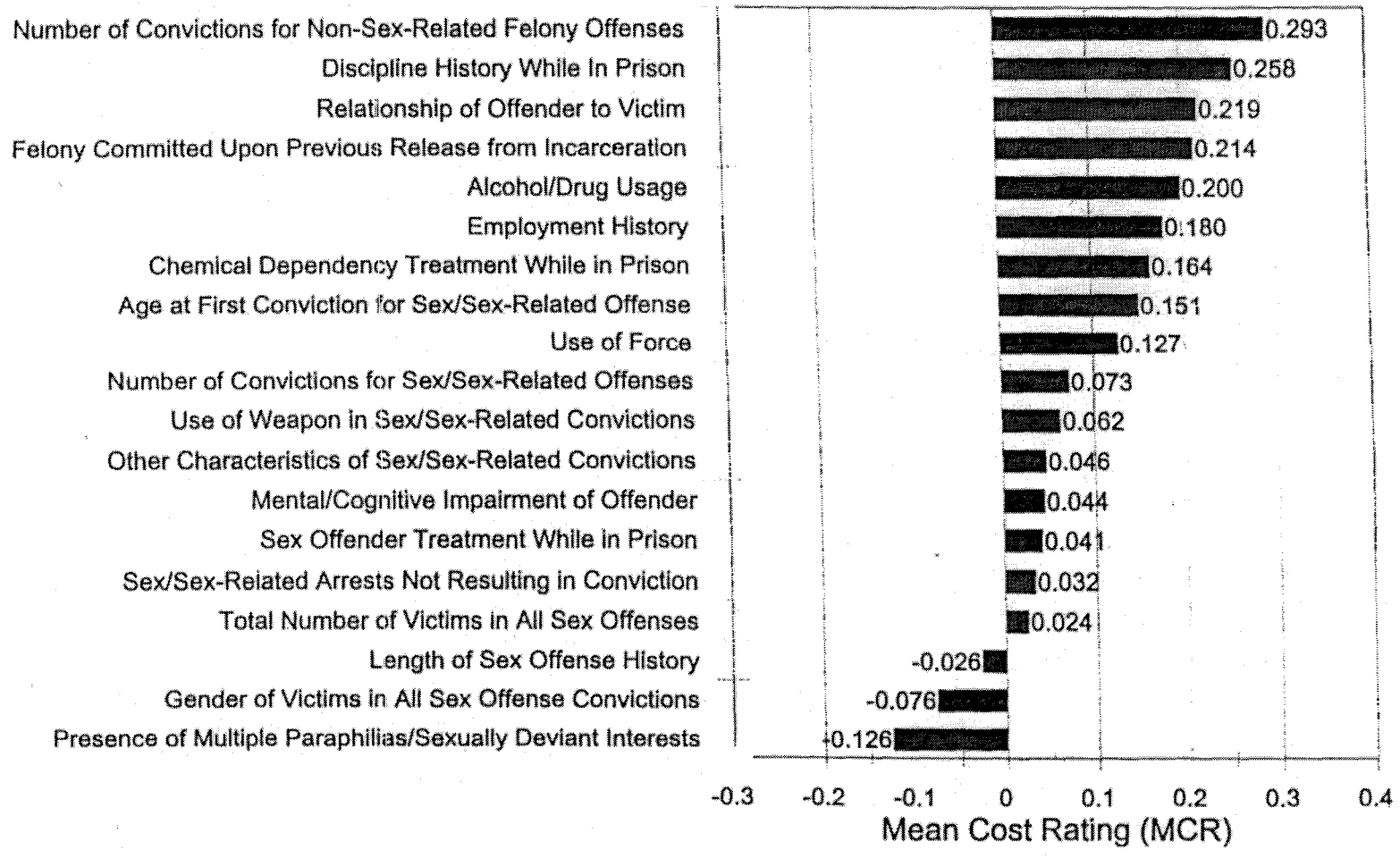
From the results above, it may be observed that some risk factors serve as efficient predictors of both types of recidivism, while others predict neither, and some predict one but not the other. For example, three factors are Very Good predictors of both general and sex offense recidivism, namely "Number of Convictions for Non-Sex-Related Felony Offenses," "Relationship of Offender to Victim," and "Felony Committed Upon Previous Release from Incarceration." Also, "Discipline History While in Prison," "Alcohol/Drug Usage," "Employment History," and "Chemical Dependency Treatment While in Prison" are all at least Good Predictors of both types of recidivism.

In contrast, three factors are Poor or Non-Predictors of both types of recidivism, including "Gender of Victims in All Sex Offense Convictions," "Presence of Multiple Paraphilias/ Sexually Deviant Interests," and "Other Characteristics of Sex/Sex-Related Convictions." The validation results suggest it would be possible to eliminate these three factors from the Risk Assessment without doing serious damage to the instrument.

"Use of Force" and "Age at First Conviction for Sex/Sex-Related Offense" are Good Predictors of general recidivism but Poor Predictors of sex offense recidivism. By the opposite token, "Number of Convictions for Sex/Sex-Related Offenses," "Use of Weapon in Sex/Sex-Related Convictions," and "Total Number of Victims in All Sex Offenses" are Very Good Predictors of sex offense recidivism but only Marginal or Poor Predictors of general recidivism. Likewise, "Sex/Sex-Related Arrests Not Resulting in Conviction," "Length of Sex Offense History," "Sex Offender Treatment While in Prison," and "Mental/Cognitive Impairment of Offender" are Good Predictors of sex offense recidivism but also Poor or Non-Predictors of general recidivism.

PREDICTIVE VALIDITY OF RISK FACTORS

General Recidivism Prediction



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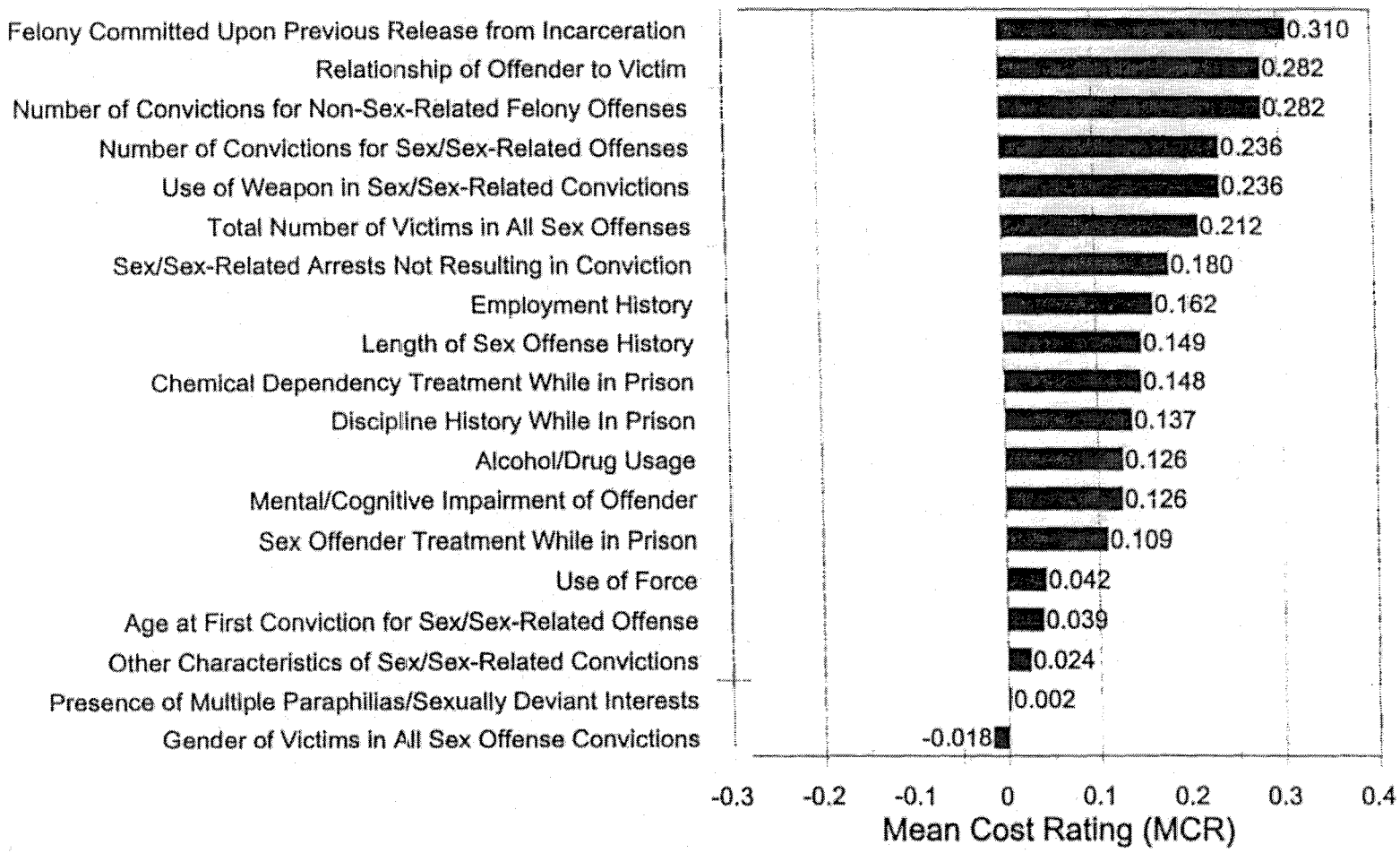
PREDICTIVE VALIDITY OF RISK FACTORS

Sex Offense Recidivism Prediction



INSTRUMENT RECALIBRATION

Given that one of the purposes of the present validation study is to consider ways and means of improving the current version of the Risk Assessment, it is certainly appropriate to look at a possible recalibration of the instrument. At present, each category of each of the 19 risk factors is assigned a weight reflecting a perception of the relative strength of that category as an indicator of sexual recidivism. For example, under the factor "Number of Convictions for Sex/Sex-Related Offenses," the category "Three or More" is assigned a weight or risk score of 6. This relatively high weight reflects the belief that sex offenders with three or more sex offense convictions pose a high risk for recidivism.

When the Risk Assessment was developed by way of modification of an instrument used in Minnesota, weights were assigned with some degree of subjectivity. Now, with the results of the follow-up study, there is an opportunity to reassign weights in a more objective fashion. This can be accomplished with simple rank orderings of risk categories according to the magnitude of recidivism rates. Revised weights are assigned separately for the two types of recidivism, with sex offense recidivism addressed first.

RISK CATEGORY	ORIGINAL WEIGHT	REVISED WEIGHT	GENERAL RECIDIVISM	SEX OFFENSE RECIDIVISM
Three or More Convictions for Sex/Sex-Related Offenses	6	10	35.1%	21.6%
Four or More Victims in All Sex Offenses	6	9	28.9%	18.4%
Three or More Convictions for Non-Sex-Related Felony Offenses	6	8	49.0%	15.7%
Felony Committed 12 Mos. or Less Following Release	4, 6, 8	7	50.0%	13.0%
IQ Under 70 or Diagnosed Mental Illness or Mood Disorder	4, 8	6	33.3%	10.7%
One or More Sex/Sex-Related Arrests Not Resulting in Conviction	4	5	28.8%	9.0%
Relationship of Offender to Victim is "Stranger"	4	5	34.1%	8.8%
Length of Sex Offense History is Five Years or More	4	5	24.1%	8.8%
Unstable Employment or in Need of Additional Employment	3	4	35.3%	7.5%
Not Involved in Chemical Dependency Treatment or Incomplete	4	4	33.2%	7.0%
Major Disciplinary Reports While Incarcerated	6	4	37.6%	6.9%
Displayed Weapon, Implied Threat, or Used to Inflict Injury	4, 6	4	37.0%	6.8%
One or Two Convictions for Non-Sex-Related Felony Offenses	2	4	38.3%	6.6%
Failed to Complete Sex Offender Treatment or Denied Admittance	5	3	27.7%	6.3%
Occasional or Frequent Alcohol or Drug Abuse	3	3	31.9%	6.3%
One or More Aggravating Factors in All Sex Offenses	4, 8	3	31.6%	6.1%
Felony Committed More Than 12 Mos. Following Release	2	3	24.5%	6.1%
Two Convictions for Sex/Sex-Related Offenses	4	3	32.9%	6.1%
Age 23 or Younger at 1st Conviction for Sex/Sex-Related Offense	3	3	36.3%	6.0%

RISK CATEGORY	ORIGINAL WEIGHT	REVISED WEIGHT	GENERAL RECIDIVISM	SEX OFFENSE RECIDIVISM
Three or More Paraphilias/Sexually Deviant Interests	4	3	14.5%	6.0%
Use of Force in Sex/Sex-Related Offenses	6	3	31.0%	5.8%
Two or Three Victims in All Sex Offenses	4	3	27.5%	5.6%
Female Victims Only in All Sex Offenses	0	0	28.2%	5.5%
Two or Fewer Paraphilias/Sexually Deviant Interests or N/A	0, 2	0	28.2%	5.3%
No Aggravating Factors in All Sex Offenses	0	0	25.4%	5.2%
No Use of Weapon in Sex/Sex-Related Convictions	0	0	25.0%	5.2%
Age 24 or Older at 1st Conviction for Sex/Sex-Related Offense	0	0	22.2%	5.1%
Male Victims Only in All Sex Offenses	2	0	16.7%	5.0%
No Use of Force in All Sex Offenses	0	0	21.1%	4.9%
Relationship of Offender to Victim is "Acquaintance"	2	0	28.6%	4.8%
Both Male and Female Victims in All Sex Offenses	4	0	18.6%	4.7%
No Known Mental Health Abnormality	0	0	25.4%	4.6%
Length of Sex Offense History is Less Than Five Years	0	0	27.0%	4.4%
Completed Sex Offender Treatment or Treatment Not Available	2	0	25.1%	4.2%
No Sex/Sex-Related Arrests Not Resulting in Conviction	0	0	25.5%	4.1%
No Major Disciplinary Reports While Incarcerated	0	0	17.4%	4.1%
One Victim in All Sex Offenses	1	0	25.7%	4.1%
One Conviction for Sex/Sex-Related Offenses	1	0	24.6%	4.0%
Stable Employment	0	0	20.6%	4.0%
No Dependency or Completed Chemical Dependency Treatment	0	0	20.4%	4.0%
No Sex Offender Treatment Required	0	0	21.4%	3.6%
No Convictions for Non-Sex-Related Felony Offenses	0	0	17.6%	3.4%
No Interference With Functioning from Alcohol/Drug Usage	0	0	13.5%	3.2%
Current Conviction is First Incarceration	0	0	21.2%	3.1%
Relationship of Offender to Victim is "Family"	0	0	12.7%	1.9%

Revised weights are assigned in proportion to the magnitude of sex offense recidivism. Of course, this places emphasis on those categories with abnormally high rates. Generally, in such cases, the revised weight is higher than the original weight assigned to the category, e.g., "Three of More Convictions for Sex/Sex-Related Offenses" is assigned 10 as opposed to the original 6. It may be observed that in some cases, a weight of 0 is assigned where a positive weight was assigned previously. The most extreme example of this is the category "Both Male and Female Victims in All Sex Offenses," where the original weight of 4 was reduced to 0. In this case, actual knowledge contradicted the presumption that sex offenders with victims of both genders were more likely to repeat than were those with single sex victims.

RISK CATEGORY	ORIGINAL WEIGHT	REVISED WEIGHT	SEX OFFENSE RECIDIVISM	GENERAL RECIDIVISM
Felony Committed 12 Mos. or Less Following Release	4, 6, 8	10	13.0%	50.0%
Three or More Convictions for Non-Sex-Related Felony Offenses	6	10	15.7%	49.0%
One or Two Convictions for Non-Sex-Related Felony Offenses	2	8	6.6%	38.3%
Major Disciplinary Reports While Incarcerated	6	8	6.9%	37.6%
Displayed Weapon, Implied Threat, or Used to Inflict Injury	4, 6	8	6.8%	37.0%
Age 23 or Younger at 1st Conviction for Sex/Sex-Related Offense	3	8	6.0%	36.3%
Unstable Employment or in Need of Additional Employment	3	8	7.5%	35.3%
Three or More Convictions for Sex/Sex-Related Offenses	6	8	21.6%	35.1%
Relationship of Offender to Victim is "Stranger"	4	7	8.8%	34.1%
IQ Under 70 or Diagnosed Mental Illness or Mood Disorder	4, 8	7	10.7%	33.3%
Not Involved in Chemical Dependency Treatment or Incomplete	4	7	7.0%	33.2%
Two Convictions for Sex/Sex-Related Offenses	4	7	6.1%	32.9%
Occasional or Frequent Alcohol or Drug Abuse	3	7	6.3%	31.9%
One or More Aggravating Factors in All Sex Offenses	4, 8	7	6.1%	31.6%
Use of Force in Sex/Sex-Related Offenses	6	7	5.8%	31.0%
Four or More Victims in All Sex Offenses	6	6	18.4%	28.9%
One or More Sex/Sex-Related Arrests Not Resulting in Conviction	4	6	9.0%	28.8%
Relationship of Offender to Victim is "Acquaintance"	2	6	4.8%	28.6%
Two or Fewer Paraphilias/Sexually Deviant Interests or N/A	0, 2	0	5.3%	28.2%
Female Victims Only in All Sex Offenses	0	0	5.5%	28.2%
Failed to Complete Sex Offender Treatment or Denied Admittance	5	0	6.3%	27.7%
Two or Three Victims in All Sex Offenses	4	0	5.6%	27.5%
Length of Sex Offense History is Less Than Five Years	0	0	4.4%	27.0%
One Victim in All Sex Offenses	1	0	4.1%	25.7%
No Sex/Sex-Related Arrests Not Resulting in Conviction	0	0	4.1%	25.5%
No Known Mental Health Abnormality	0	0	4.6%	25.4%
No Aggravating Factors in All Sex Offenses	0	0	5.2%	25.4%
Completed Sex Offender Treatment or Treatment Not Available	2	0	4.2%	25.1%
No Use of Weapon in Sex/Sex-Related Convictions	0	0	5.2%	25.0%
One Conviction for Sex/Sex-Related Offenses	1	0	4.0%	24.6%
Felony Committed More Than 12 Mos. Following Release	2	0	6.1%	24.5%
Length of Sex Offense History is Five Years or More	4	0	8.8%	24.1%
Age 24 or Older at 1st Conviction for Sex/Sex-Related Offense	0	0	5.1%	22.2%
No Sex Offender Treatment Required	0	0	3.6%	21.4%

RISK CATEGORY	ORIGINAL WEIGHT	REVISED WEIGHT	GENERAL RECIDIVISM	SEX OFFENSE RECIDIVISM
Current Conviction is First Incarceration	0	0	3.1%	21.2%
No Use of Force in All Sex Offenses	0	0	4.9%	21.1%
Stable Employment	0	0	4.0%	20.6%
No Dependency or Completed Chemical Dependency Treatment	0	0	4.0%	20.4%
Both Male and Female Victims in All Sex Offenses	4	0	4.7%	18.6%
No Convictions for Non-Sex-Related Felony Offenses	0	0	3.4%	17.6%
No Major Disciplinary Reports While Incarcerated	0	0	4.1%	17.4%
Male Victims Only in All Sex Offenses	2	0	5.0%	16.7%
Three or More Paraphilias/Sexually Deviant Interests	4	0	6.0%	14.5%
No Interference With Functioning from Alcohol/Drug Usage	0	0	3.2%	13.5%
Relationship of Offender to Victim is "Family"	0	0	1.9%	12.7%

Here weights are assigned based on the magnitude of the general recidivism rate. As in the case of sex offense recidivism, only categories on the positive side of risk, e.g., negative characteristics of the offender, are assigned positive weights. However, not all such categories are assigned positive weights. For example, the category "Two or Three Victims in All Sex Offenses" is a positive category or negative characteristic, but is nonetheless assigned a weight of "0." It may also be noted that many of the categories serve as predictors of both types of recidivism, the category "Three or More Convictions for Non-Sex-Related Felony Offenses" being a prime example. However, the weights assigned are obviously different in recognition of different types of outcome.

In each case, the assigned weights form the basis for a new, and hopefully improved, risk prediction instrument. The two new risk assessments, which will be referred to as "Sex Offense Risk" and "General Recidivism Risk" are obtained by addition of all relevant weights for each offender in the study. Their respective risk levels are defined based on the magnitude of the total risk score (sum of weights) as follows:

Sex Offense Risk	Range
Very High Risk	48+
High Risk	31-47
Intermediate Risk	21-30
Lower Risk	0-20

General Recidivism Risk	Range
Ultra High Risk	69+
Very High Risk	53-68
High Risk	45-52
Intermediate Risk	20-44
Lower Risk	0-19

The following tables indicate the numbers of sex offenders falling in each risk level of the two scales, as well as the numbers and percentages of sex offenders classified in each risk level who were found to be recidivists.

SEX OFFENSE RISK	TOTAL CASES	REARREST FOR SEX OFFENSE	% REARREST FOR SEX OFFENSE
Very High Risk	31	10	32.3%
High Risk	131	12	9.2%
Intermediate Risk	179	7	3.9%
Lower Risk	273	4	1.5%
ALL CASES	614	33	5.4%

GENERAL RECIDIVISM RISK	TOTAL CASES	REARREST FOR VIOLENT/SEX/ FELONY OFFENSE	% REARREST FOR VIOLENT/SEX/ FELONY OFFENSE
Ultra High Risk	32	21	65.6%
Very High Risk	90	44	48.9%
High Risk	83	29	34.9%
Intermediate Risk	300	63	21.0%
Lower Risk	109	5	4.6%
ALL CASES	614	162	26.4%

The charts on pages 19-20 illustrate the above results. In addition, they indicate a correlation coefficient (MCR) of 0.537 for the prediction of sex offense recidivism by sex offense risk and 0.440 for the prediction of general recidivism by general recidivism risk. These values of MCR are much higher than were the comparable coefficients for the current Risk Assessment (0.277 and 0.276 respectively) and suggest the utility of moving to the new assessment scales.

To a certain extent, the higher correlation coefficients for the new scales are to be expected because they represent the use of the study data as a "construction sample" as opposed to a "validation sample." In other words, we had the benefit of the follow-up results in formulating the new scales. On the other hand, the new scales represent actual as opposed to presumed knowledge of risk factors as gained from the study, and thus should provide better approaches to sex offender risk assessment in the longer term.

Should the decision be made at some point in the future to base sex offender notification in Arizona on the proposed scales, it would be necessary to collapse the two scales into a single 3-level scale, i.e., Level I, Level II, and Level III. After careful review, the following is recommended for this purpose, should the need arise.

LEVEL I (Lower Risk)

Lower Sex Offense Risk and Lower General Recidivism Risk

LEVEL II (Intermediate Risk)

Intermediate Sex Offense Risk or Intermediate General Recidivism Risk
(Excluding Offenders in Level I and Level III)

LEVEL III (High Risk)

High or Very High Sex Offense Risk or Very High or Ultra High General Recidivism Risk

This set of assignments to the three risk/notification levels would result in the following distribution of released ADC sex offenders among the levels:

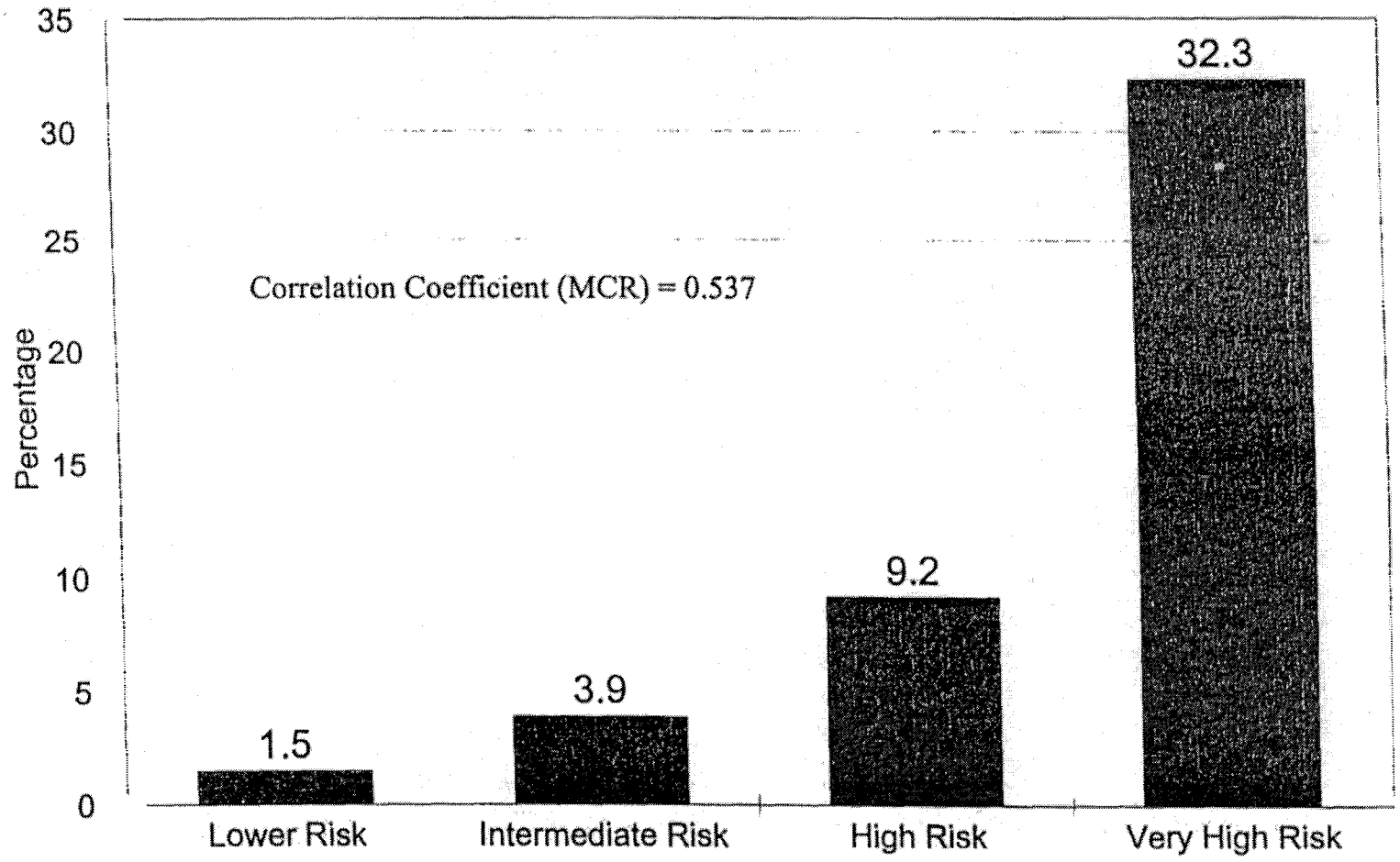
- ✓ 106 cases (17.3%) would be classified as ***Level I*** (Lower Risk)
- ✓ 334 cases (54.4%) would be classified as ***Level II*** (Intermediate Risk)
- ✓ 174 cases (28.3%) would be classified as ***Level III*** (High Risk)

This assignment strategy would increase the percentage of sex offenders classified as Level I from 9.3% to 17.3% and the percentage classified as Level III from 19.4% to 28.3%. In compensation, the percentage classified as Level II would drop from 71.3% to 54.4%.

The charts on pages 21-22 illustrate the validity of the recommended risk/notification levels for the prediction of sex offense and general recidivism. As indicated, the correlation coefficients (MCR) come to 0.446 for sex offense recidivism and 0.368 for general recidivism. As was the case with Sex Offense Risk and General Recidivism Risk, the values of these coefficients are substantially higher than the comparable coefficients for the current system of levels (0.277 and 0.276).

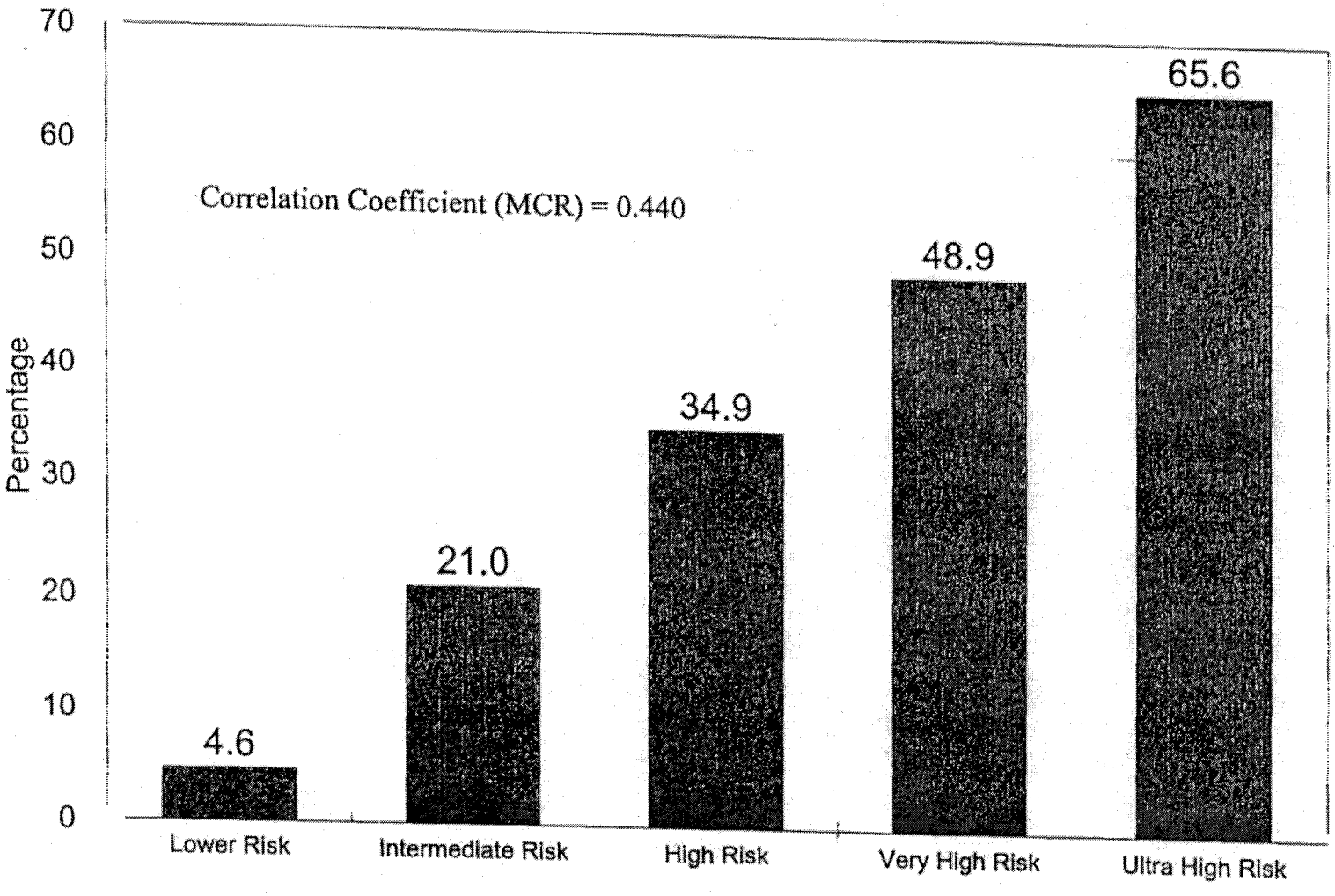
REARREST (SEX OFFENSE)

By Sex Offense Risk



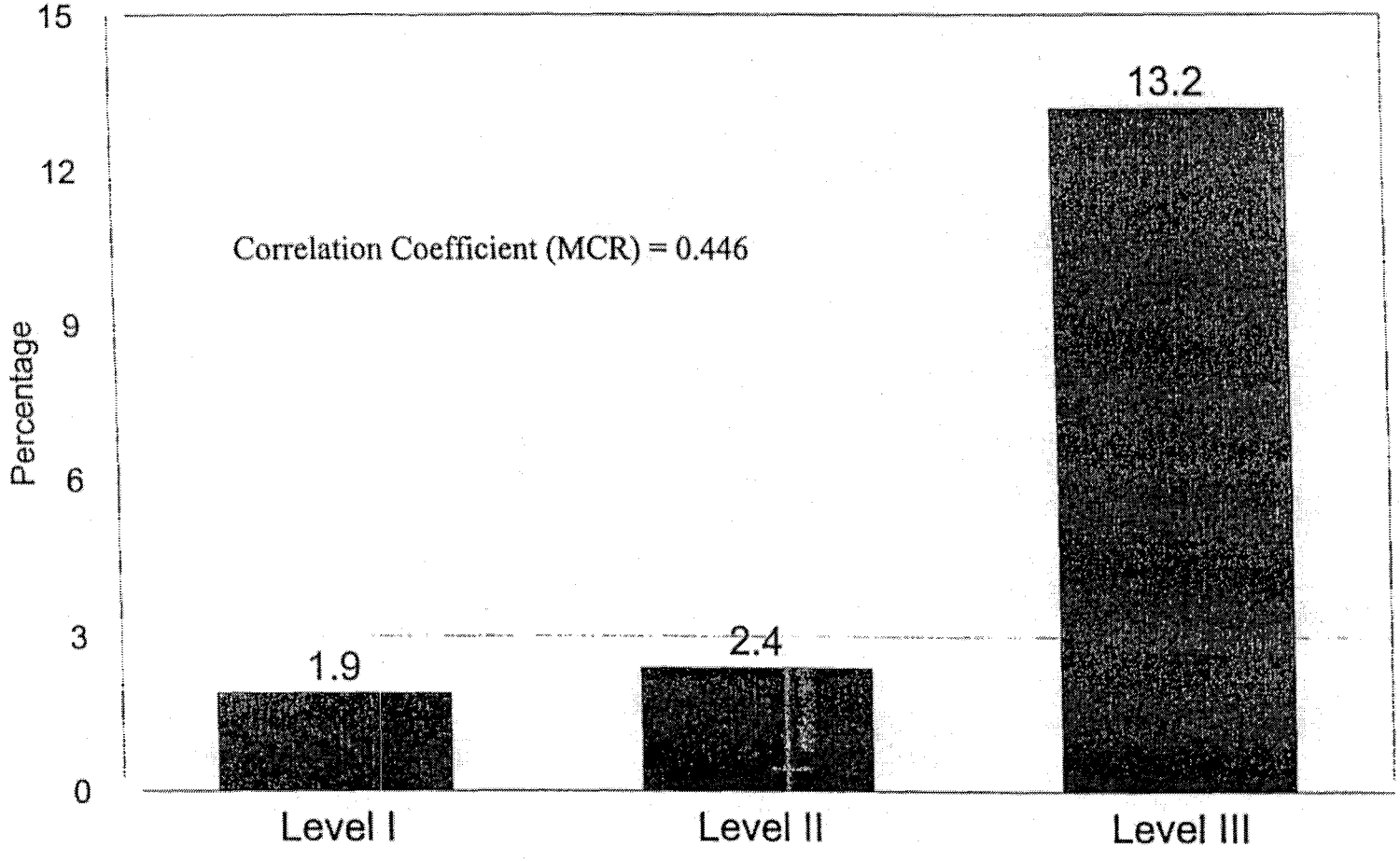
REARREST (VIOLENT/SEX/FELONY OFFENSE)

By General Recidivism Risk



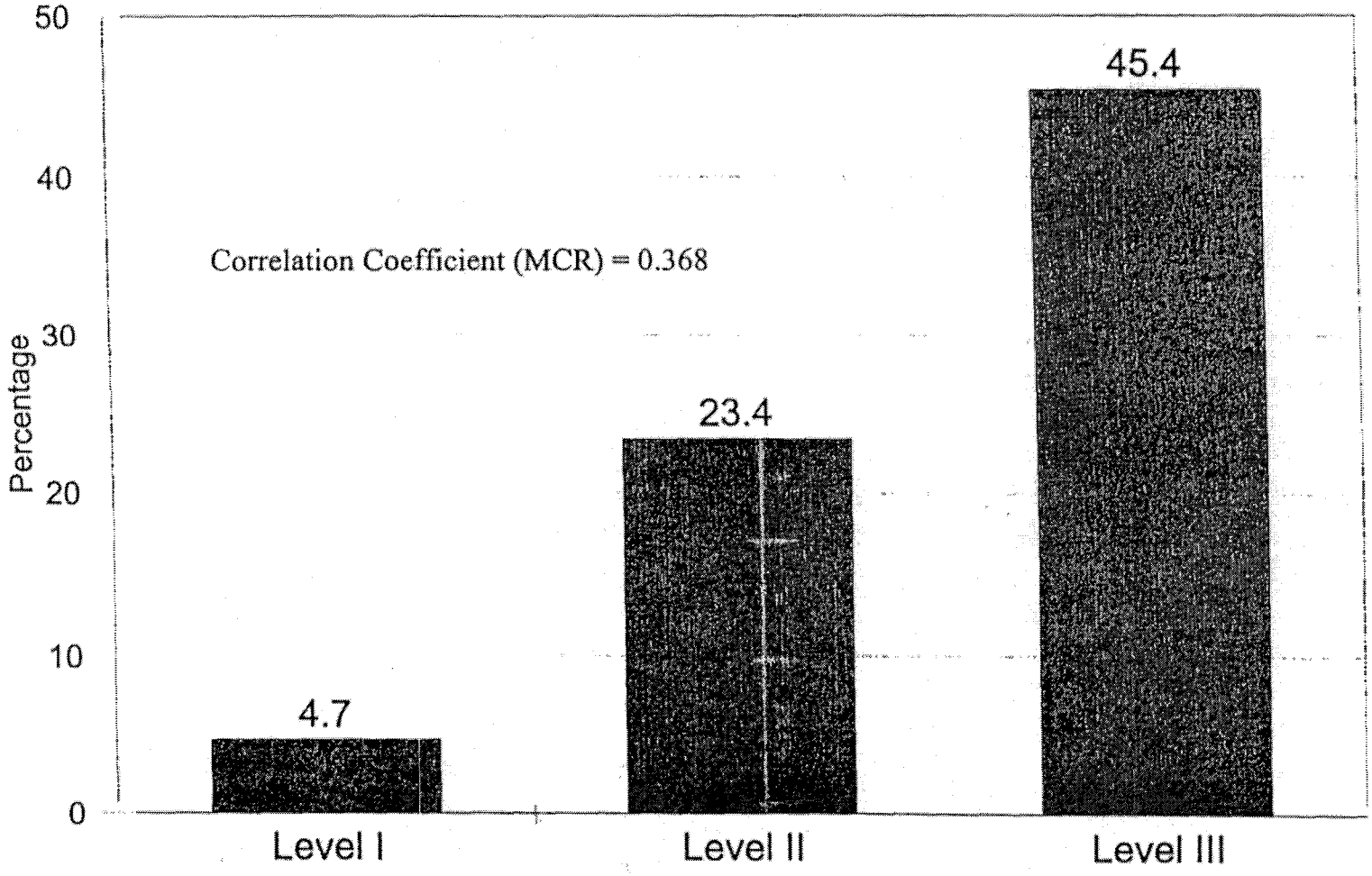
REARREST (SEX OFFENSE)

By Recommended Risk/Notification Level



REARREST (VIOLENT/SEX/FELONY OFFENSE)

By Recommended Risk/Notification Level



SEX OFFENDER RECIDIVISM

In previous sections of the report, follow-up results were presented as a function of the risk/notification level of the offender and of the various risk factors which contribute to the risk assessment. It was necessary to present the results in this fashion in order to determine the validity of the instrument and to consider possible improvements. In this regard, it was not necessary to consider results for the notification group as a whole. In this section, we compare follow-up results between the ADC notification group, consisting of 614 released sex offenders, and the registration-only group, consisting of 212 released offenders with prior but no current sex offenses on their records. While this information is not essential to the purpose of the report, it does serve to further document the results of the follow-up study.

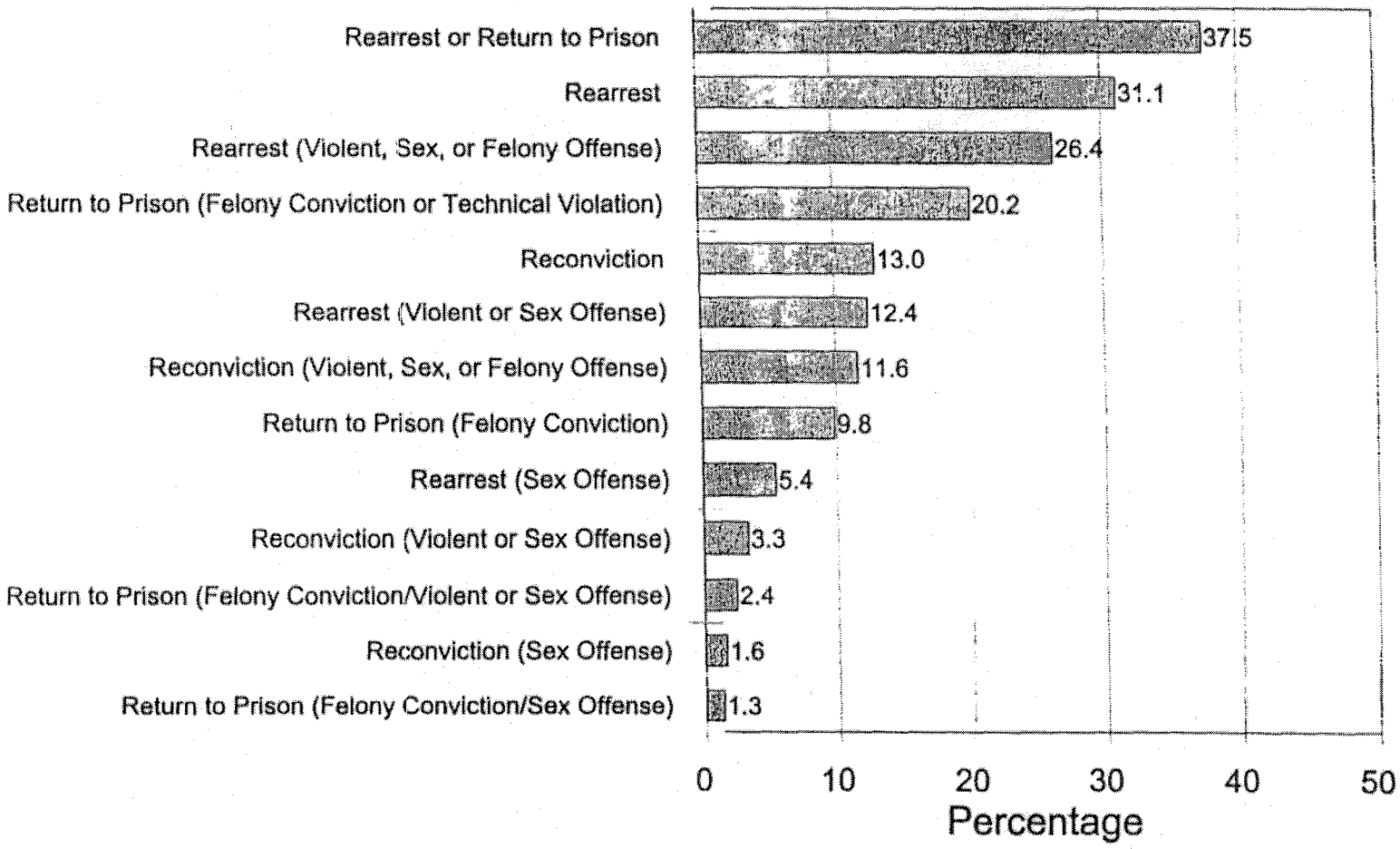
To this end, the two charts on pages 24-25 present follow-up results for the two groups in relation to 13 separate measures of recidivism. This includes the nine (9) measures examined in conjunction with the risk assessment validation, plus four (4) additional measures which provide a more comprehensive view of recidivism for the notification and registration-only groups. These include "Reconviction (Violent or Sex Offense)," "Return to Prison (Violent or Sex Offense)," "Reconviction (Sex Offense)," and "Return to Prison (Sex Offense)."

As can be noted from a comparison of the two charts, the registration-only group recorded much higher recidivism rates in general than did the notification group. This is due primarily to the fact that the former group includes a higher concentration of repeat offenders. All offenders in the registration-only group had prior records of sex offenses and thereby could be considered repeat offenders at the time of their current convictions. Many of these offenders had current and even prior convictions for other types of crimes (violent, property, drug, and public order offenses) and would be at relatively high risk for repeating these offenses. In contrast, many offenders in the notification group were one-time-only sex offenders who may have posed a greater risk of sexual re-offending but a much lower risk of re-offending in some other manner. In this regard, the exceptions to higher recidivism rates for the registration-only group fall in the category of new sex offending. The sex offense rearrest rate, for example, was 5.4% for the notification group and 4.2% for the registration-only group.

It should be noted that the follow-up period for this study is still relatively short, i.e., approximately 34 months, and accordingly the recidivism rates given in the charts are smaller than they would be in a longer-term study. In the near future, the ADC Research Unit will be finalizing the results of a follow-up study of 3,000+ sex offenders released from the department over a 15-year period beginning in 1983. This study will include FBI follow-up data and will provide recidivism rates applicable to follow-up periods as long as 14 years. This study should provide an even more accurate picture of recidivism for released sex offenders in Arizona than does the current validation study.

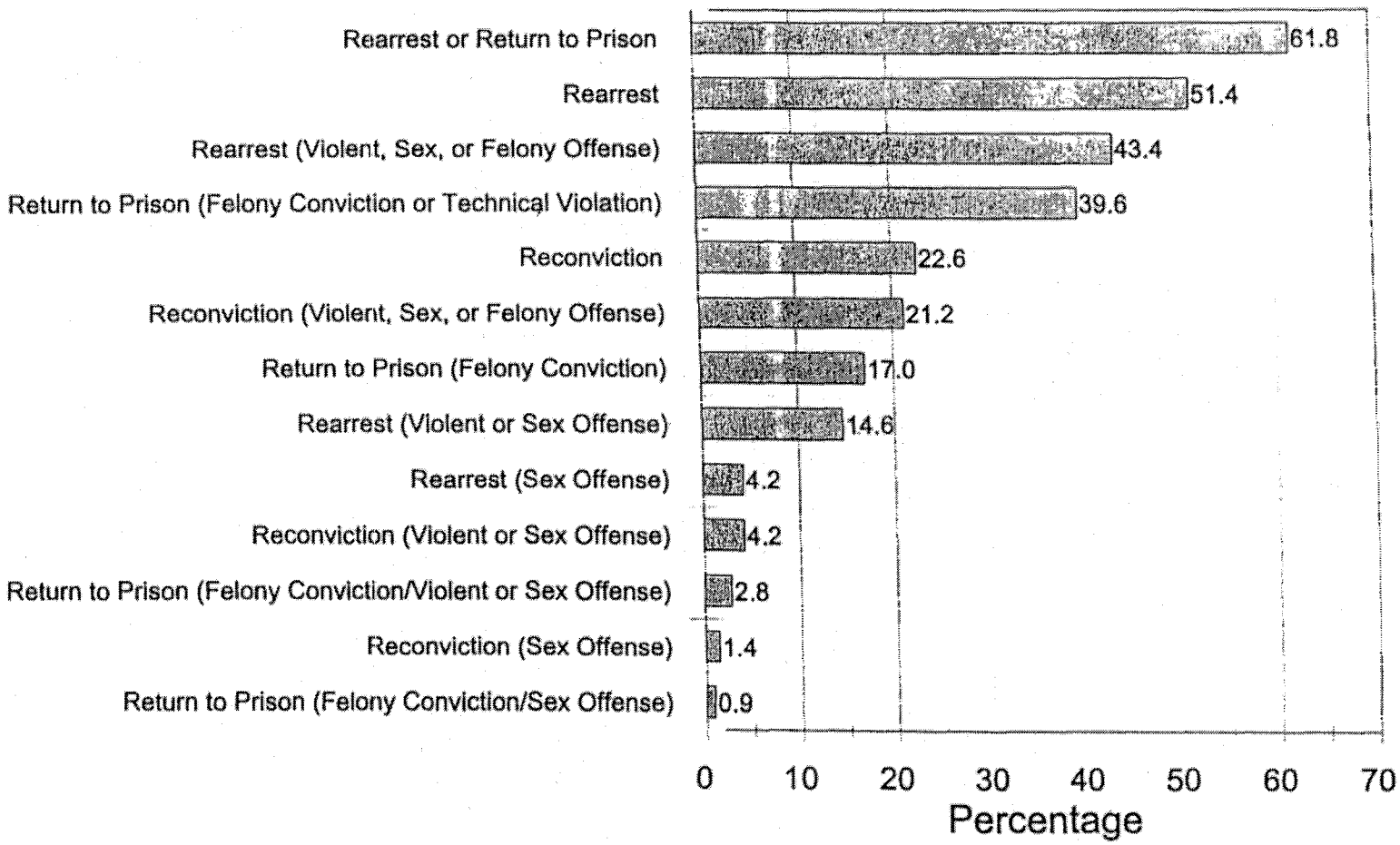
RECIDIVISM FOLLOW-UP RESULTS

ADC Notification Cases (614)



RECIDIVISM FOLLOW-UP RESULTS

ADC Registration-Only Cases (212)



ARIZONA SEX OFFENDER ASSESSMENT SCREENING PROFILE

FOR REGULATORY COMMUNITY NOTIFICATION

ARIZONA SEX OFFENDER ASSESSMENT SCREENING PROFILE
FOR REGULATORY COMMUNITY NOTIFICATION

FINAL 6-1-96
Revised 9-10-96

Reminder: This instrument is to be used by law enforcement as a guideline for regulatory community notification purposes.

COMPLETED BY: _____ Offender Name: _____ NUMBER: _____
(Agency/Initials) Date: _____

1. Number of Convictions for Sex/Sex Related Offenses
(Including current offenses)

a. None 0
b. One 1
c. Two 4
d. Three or More 6

(Actual #: ___) Score: ___

2. Number of Convictions for Felony Offenses
(Excluding sex/sex related offenses)

a. None 0
b. One or Two 2
c. Three or More 6

(Actual #: ___) Score: ___

3. Other Sex/Sex Related Charges Not Resulting in Conviction

a. None 0
b. One or More 4

(Actual #: ___) Score: ___

4. Age at First Conviction for Sex/Sex Related Offense

a. 24 or Older 0
b. 23 or Younger 3

(Actual #: ___) Score: ___

5. Use of Weapon in Sex/Sex Related Conviction(s)
(Most Severe)

a. None Present 0
b. Displayed During Offense/Implied Threat . . . 4
c. Used to Inflict Injury 6

Score: ___

6. Total Number of Victims in All Sex Conviction(s)

a. None 0
b. One 1
c. Two or Three 4
d. Four or More 6

(Actual #: ___ Score: ___

7. Gender of Victims

a. Females 0
b. Males 2
c. Crossover 4

Score: ___

8. Relationship of Offender to Victim

a. Family 0
b. Acquaintance 2
c. Stranger 4

Score: ___

9. Use of Force (Most Severe)

a. None 0
b. Manipulative 0
c. Coercive/Position of Authority 0
d. Threats of Violence 6
e. Physical Force or Violence 6
f. Substantial/Great Bodily Harm 6

Score: ___

10. Other Characteristics of Sex/Sex Related Conviction(s)
(May score more than one)

a. None 0
b. Victim Tied Up 4
c. Actual or Estimated Duration of Crime is more than 3 hours 4
d. Victim Transported Forcefully to Another Location 4
e. Victim Tortured/Mutilated 4

Score: ___

11. Length of Sexual Offense History

a. 0 to Five Years 0
b. Five Years or More 4

Score: ___

12. Alcohol/Drug Usage

a. No Interference With Functioning 0
b. Occasional or Frequent Abuse 3

Score: ___

6-1-96
Revised 9-10-96

13. Mental/Cognitive Impairment of Offender
(May have more than 1)
a. No Known Mental Health Abnormality 0
b. IQ under 70 4
c. Diagnosed Mental Illness or mood disorder .. 4

Score: ___

14. Employment History

a. Stable Employment 0
b. Unstable or in Need of Additional Employment 3

Score: ___

15. Presence of Multiple Paraphilias/Sexually Deviant Interests (Check all that apply)

__ Fetishism
__ Pedophilia
__ Voyeurism
__ Obscene Phone Calling
__ Bestiality
__ Exhibitionism
__ Frotteurism/Frottage
__ Sexual Sadism
__ Sexual Masochism
__ Rape
__ Other(s)

a. None or One 0
b. Two or Source not Available 2
c. Three or More 4

(Actual #: ___) Score: ___

16. Felony Committed Upon Previous Release from Institution

a. Not Applicable (First Incarceration) 0
b. More than 12 Months Following Release ... 2
c. 7 to 12 Months Following Release 4
d. 4 to 6 Months Following Release 6
e. Less than 3 Months Following Release 8

Score: ___

17. Discipline History While In Prison
(Most Serious)

a. No Major Reports 0
b. Major Reports with or without violence 6

Score: ___

****
**

TOTAL OVERALL ASSESSMENT SCORE: ___

COMMENTS:

LEVELS	
0-14	I
15-39	II
40-Above	III

18. Chemical Dependency Treatment While In Prison

a. No Dependency or Completed Program 0
b. Not Involved in Treatment, Involved yet not Completed 4

Score: ___

19. Sex Offender Treatment While In Prison

a. No Treatment Required 0
b. Completed Treatment or Required Treatment but Treatment not Available 2
c. Treatment Required and Failed to Complete or Failed to take part or was Denied Admittance 5

Score: ___

****

NOT PART OF THE SCREENING CRITERIA

Mitigating Circumstances Which May Effect the Extent of Regulatory Community Notification Made:

1. Quality of Release Environment to Include:

a. Present Employment
b. Involvement in Treatment Programs
c. Residential Environment
d. Family Support System

****
**

FOR LAW ENFORCEMENT USE ONLY

Override may be considered to level 3 status if any of these factors are present:

1. Deadly weapon or dangerous instrument used during the offense
2. Victim tortured or mutilated; great bodily harm
3. Victim transported forcefully to another location

****
**

SUGGESTED NOTIFICATION LEVEL: ___

DNA SAMPLE COLLECT DATE: _____

Sex Offender Notification Survey:
Summary of Results

September 2004

Purpose: In September 2004 a survey was distributed to criminal justice agencies responsible for completing the Arizona Sex Offender Assessment Screening Profile for Regulatory Community Notification and conducting community notifications. The purpose of the survey was to assess current practices of community notification. It was also designed to identify areas of concern related to the notification profile assessment tool and the community notification process.

Survey Responses: The survey was distributed to 87 different criminal justice agencies. There were 28 responses to the surveys for a 32% response rate. Descriptive information about the survey respondents is provided below:

- Responses were received from 13 of the 15 counties within Arizona.
- The number of responses per county ranged from 1 to 9
- The majority of responses were from law enforcement agencies (Police Departments, N=19, 67.9%; Sheriff Departments, N=6, 21.4%) There were three responses (10.7%) from probation departments.[1]

Experience with the Risk Assessment Tool: The majority of agencies responding have only one or two people who conduct the assessments (N=22, 78.6%). Only four agencies (14.3%) indicated that they have more than two people responsible for conducting the assessment.

The amount of experience with the assessment tool varies. Approximately one-third (N=10) have been using the tool for 2 years or less. Four agencies indicated they have been using the tool since it was created. The length of experience is presented in Table 1.

Table 1: Length of Time Using Risk Assessment Tool

Length of Time	Number of Agencies	% of Agencies
2 years or less	10	35.7
Between 2 and 5 years	5	17.9
More than 5 years	5	17.9
Since the tool was created	4	14.3
Not specified	4	14.3

[1] Because the majority of the survey responses were from law enforcement agencies, all responses will be presented together. There were not enough responses from supervision agencies to allow a comparison of the results between these two groups.

Method of Notification: The most common methods of community notification are door-to-door and through the media. Table 2 describes the methods of notification used by those who responded.

Table 2: Method of Notification Used

Method of Notification	# of Agencies	% of Agencies
Door-to-Door	23	82.1
Media	21	75.0
Mail	10	35.7

Comments were also provided indicating some other methods of notification that have been used. These include:

- Community college newsletters
- Community meetings
- Public postings
- Internet
- Email
- Fax to school districts and other police departments
- School notification in person

Size of Notification Area: The size of the notification area varies. Table 3 presents the responses to the size area used for the notification of Level 3 sex offenders.

Table 3: Size of Notification Area for Level 3 Sex Offenders

Size of Notification Area	# of Agencies	% of Agencies
Up to 2 blocks	4	14.3
3 to 6 blocks	8	28.6
Up to a mile	7	25.0
Natural Geographic Boundaries	6	21.4
Other	1	3.6
Not Applicable	2	7.1

The comments included on the survey suggest that there is some variation in the size of the notification area depending on where the sex offender is located. The comments provide some insight into the factors that affect the size of the notification area. Relevant comments are provided below:

- Due to our diverse geography, a near neighbor can be 2 miles away. We use officer judgement to fulfill this requirement.
- Generally 2 blocks but with some rural areas we may notify 2 to 3 miles
- Wherever we feel it is necessary
- Notify nearest schools and daycare

Another issue identified was changes in legislation. One agency indicated that due to changes in the law, they are thinking about shortening notification coverage to ¼ mile.

Factors impacting the size of the notification area: Other factors were identified that impact the size of the notification area. The most common factor is the risk level (N=20). These are presented in Table 4 below.

Table 4: Factors Impacting Size of Notification Area

Factors Impacting Size of Notification Area	# of Agencies	% of Agencies
Risk Level	20	71.4
Aggravating/Mitigating Factors	13	46.4
Department Policy	4	14.3
Manpower	4	14.3
Cost	2	7.1
Other	4	14.3

Some of the other comments included:

- As required by ARS
- Geography of area where offender resides
- One square mile surrounding offender's address

Assessment Score Used: Survey respondents were asked whose assessment score they used to determine the final level for notification. The majority indicated they used the score of the law enforcement agency (N=16, 57.1%). The score of the supervision agency was used by 6 (21.4%). Three agencies indicated other. In the comments these agencies indicated that all assessment information was reviewed and compared.

Reevaluation of Assessment Scores: Survey respondents were asked if they engaged in reevaluation of the risk assessment score that determines notification level and when they conduct the reevaluation. The most common response was that reevaluation occurs when there is documentation of changes (N=13, 46.4%). Other responses are provided in Table 5 below.

Table 5: Reevaluation of Assessment Score

When Reevaluation Occurs	# of Agencies	% of Agencies
Documentation of Changes	13	46.4
New Conviction	8	28.6
Never	4	14.3
Other	2	7.1
Missing	1	3.6

Some of the comments that were made in this area include:

- If DPS reevaluates, we change the sex offender level.
- If moved from our jurisdiction and moved back.

Discretion in Definition of Assessment Criterion: Almost half of survey respondents (N=12, 42.9%) indicated that they allow discretion in the definition of the assessment criterion. This tends to be allowed when a change occurs and if they are aware of the changes. One example of discretion was provided. The survey respondent indicated "If the offender was recently released from DOC or jail and does not have a job, after they obtain a job and hold a job for one month I will reevaluate that offender and give credit for stable employment."

Training: Survey respondents were asked if anyone responsible for administering the tool was not formally trained. The majority (N=19, 67.9%) indicated that they did not have staff using the tool who had not received formal training. However, eight respondents (28.6%) indicated they had staff using the tool who were not formally trained. Very few comments were provided to indicate why staff were not formally trained. One comment was made that training opportunities are never known.

Differences in Assessment Scores: Survey respondents were asked what they do when there is are differences in the assessment scores for the same sex offender. Based on the survey responses, there appears to be a great deal of collaboration between agencies in these situations. The majority (N=18, 64.3%) indicated that they discuss the differences with other agencies. A few respondents indicated they use their score and disregard the other (N=3, 10.7%). Some of the comments describing what agencies do are provided below.

- Discuss the differences and use the score obtained after the discussion
- Check with other agency who did the initial assessment
- Contact the police agency to discuss differences. Usually they're pretty similar
- More research
- We make personal contact with the other agency and discuss what factors are different that would make the score different
- We would research why scores did not match and use ours

Questions: The majority of survey respondents indicated that they contact the DPS Sex Offender Compliance Unit when they have questions (N=21, 75%). There were six (21.4%) agencies who indicated they contact someone within another agency. In addition, four respondents indicated that they have multiple sources they go to when there are questions. Only one respondent indicated that they haven't been able to locate someone to respond to questions.

Matching Items: Survey respondents were asked how often scores match when there are multiple assessment scores. The responses are provided in Table 6.

Table 6: Frequency of Matched Assessment Scores

Frequency of Matched Scores	# of Agencies	% of Agencies
Usually	16	57.1
Sometimes	3	10.7
50/50	3	10.7
Missing	6	21.4

Problems: Survey respondents were asked if there were recurring problems completing the assessment tool. The majority indicated no (N=16, 57.1%). However, there were 10 (35.7%) that indicated there were recurring problems. The majority of the comments provided indicated that the problems relate to difficulty obtaining information. Some of the comments are provided below.

- Getting information on subject ie original crime reports, jail records
- It is difficult to get old reports from the appropriate agency
- Sometimes difficult to obtain supporting documents (police reports, proof of treatment) especially from out-of-state offenders
- The greatest barrier is the lack of information from other jurisdictions (esp if out of state)
- The question regarding sex offenders treatment does not address those actively participating in an approved sex offender treatment program. It only allows for completion of a program or failure to participate or comply.

Areas of concern:

- The tool seems to be open to the way the assessor reads into the question other than what the offender has done.
- Manpower is a big problem (for conducting notifications)
- It (the assessment) has to do with the charges and convictions. Two DR's, one conviction. I don't always have the necessary paperwork from most of the sex offenders I receive to do a complete or accurate assessment.
- Manpower is always going to be an issue. Notification is an additional duty on top of a substantial investigative caseload.
- We don't have the manpower to do it (notification), we are a very small department and have to take time off other duties to do notification.

Recommendations for solving problems associated with the risk assessment tool: The survey asked respondents for recommendations that would help solve the problems associated with the risk assessment tool. These recommendations are summarized below:

- Keep it simple
- A sex offender should not be rated as a level 2 if only the general recidivism score is up. Sex scores should be the determining factor for notification.
- Have a more structured formal training for all agencies to be on the same page (and also for new people new to the job). Tools that are able to be downloaded for newbies to get started would also be helpful.
- Allow a scoring factor for those actively participating in sex offender treatment. Currently, the question seems to assume that treatment was completed and therefore a zero risk score is indicated, or that they are not addressing the issue and a higher risk score of 3 is indicated. A person who is actively addressing the issue in a therapeutic environment does not fit either risk category. It would seem that they would fall somewhere in between the two risk scores allowed.
- Semi-annual or annual training on the risk assessment tool
- Have the agency that does the risk assessment do the notification
- To have updated training every six months or yearly for agencies who do very few assessments a year. Because or our size, assessments fall into general investigations due to the fact we don't have a sex offender unit
- Simplify the assessment
- I believe that the current assessment tool is confusing and takes more time to complete than the tool from 1996. Recidivism rates have no bearing on my community notification, the final risk to the community does. I suggest we either go back to the 1996 tool or create two different forms, one for DOC that deals with recidivism and the other for law enforcement that deals with risk.

Recommendations for solving problems associated with conducting community notification: The survey also asked respondents for recommendations that would help solve problems associated with conducting community notifications. These recommendations are summarized below:

- Have someone define the surrounding neighborhood.
- Have a committee that one can turn to should a question arise.
- Have set guidelines to refer to should one need assistance.
- Produce software for flyers and pictures
- It would be nice to mail flyers but it won't happen at our agency. Our agency likes us to talk directly with the community
- Better communication between agencies responsible for completing risk assessments and community notification
- Pamphlets explaining notification and citizens concerns and questions. We are sometimes inundated with phone calls from the public after an initial notification.
- Make the public responsible for obtaining the information on sex offenders. There are many places to retrieve the information we give out on the flyers.
- Get rid of the current assessment tool and go back to the 1996 tool.

Notification Profile Comparison Results

Data included in the results are the result of a request for notification profile comparisons from law enforcement agencies in Arizona (See risk assessment worksheet for details). Phoenix PD supplied additional notification profile comparisons so that a larger sample could be reviewed.

100 total notification profile comparisons included.

81 comparisons from Phoenix PD

19 comparisons from other agencies

5 – Chandler; 3 – Gilbert; 5 – Mesa; 3 – Sierra Vista; 3 – Tucson PD

*Pinetop-Lakeside PD, Apache Junction PD, Page PD, Holbrook PD responded but only one risk assessment is completed between Law Enforcement and Supervision agencies so no comparison is possible.

Supervision Agencies represented in the comparisons.

66 – AZ Department of Corrections; 29 – Maricopa County Adult Probation; 3 – Pima County Adult Probation; 1 – U.S. Probation; 1 – Cochise County Adult Probation

Results based on notification profile level.

	Agree	Disagree
Overall Level	77% (77/100)	23% (23/100)
Phoenix Only	78% (63/81)	22% (18/81)
Other LE Agencies	74% (14/19)	26% (5/19)

Results based on risk notification profile score.

	Agree	Disagree
Overall Scores	14% (14/100)	86% (86/100)
Phoenix Only	12% (10/81)	88% (71/81)
Other LE Agencies	21% (4/19)	79% (15/19)

Discrepancy results based on individual notification profile questions.

	Overall	Phoenix	Other Agencies
Question 1	13% (13/100)	15% (12/81)	5% (1/19)
Question 2	16% (16/100)	17% (14/81)	11% (2/19)
Question 3	13% (13/100)	12% (10/81)	16% (3/19)
Question 4	9% (9/100)	9% (7/81)	11% (2/19)
Question 5	5% (5/100)	2% (2/81)	16% (3/19)
Question 6	12% (12/100)	11% (9/81)	16% (3/19)
Question 7	7% (7/100)	6% (5/81)	11% (2/19)
Question 8	19% (19/100)	20% (16/81)	16% (3/19)
Question 9	10% (10/100)	10% (8/81)	11% (2/19)
Question 10	4% (4/100)	5% (4/81)	0% (0/19)
Question 11	16% (16/100)	15% (12/81)	21% (4/19)
Question 12	12% (12/100)	14% (11/81)	5% (1/19)
Question 13	8% (8/100)	7% (6/81)	11% (2/19)
Question 14	20% (20/100)	19% (15/81)	26% (5/19)
Question 15	28% (28/100)	29% (24/81)	21% (4/19)
Question 16	12% (12/100)	11% (9/81)	16% (3/19)
Question 17	8% (8/100)	6% (5/81)	16% (3/19)
Question 18	18% (18/100)	16% (13/81)	26% (5/19)
Question 19	15% (15/100)	11% (9/81)	32% (6/19)

* numbers contained within ( ) indicate the number of positive or negative responses versus the total number of possible responses in the category.

Community Notification Guidelines Committee
11/10/04
Adopted Recommendations

1. The Community Notification Guidelines Committee recommends that the Legislature continue to study and analyze whether developing a process to allow a sex offender to have a review of their requirement for community notification as a sex offender is the appropriate public policy for this state.

2. If any ambiguity remains when the 47th Legislature convenes, the Community Notification Guidelines Committee recommends that legislation be introduced in the 47th Legislature, 1st Regular Session to clarify that Laws 2004, Chapter ~~308~~ 272 is intended to apply only to offenders released after the effective date of this act and offenders who as a result of moving after the effective date of this act are subject to a new risk assessment by law enforcement.

3. The Community Notification Guidelines Committee recommends that the Legislature research and develop a central entity to coordinate sex offender related efforts. The Committee would request that JLBC look into the cost of implementing a central entity. The Legislature should determine the scope of the central entity in reference to:
    1. Whether the entity is an independent board or part of an existing agency
    2. Whether the entity should conduct risk assessments statewide
    3. What a review process for a sex offender's community notification requirement should consist of, if the Legislature decides that a review process is the appropriate policy.

BACKGROUND MATERIAL

April 20, 2026

PENDING LEGISLATION

SB1709

ARIZONA HOUSE OF REPRESENTATIVES

57th Legislature, 2nd Regular Session
Majority Research Staff
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SB 1709: dangerous crimes; children; probation revocation
Sponsor: Senator Shamp, LD 29
Committee on Judiciary

Overview

Enhances probation revocation requirements for adult defendants convicted of a dangerous crime against children (DCAC) by making rearrest, probation revocation and consecutive imprisonment mandatory, rather than discretionary, after a new offense or probation violation.

History

Under current law, if a defendant is eligible for probation, the court may suspend the imposition or execution of sentence and place the defendant on intensive, supervised or unsupervised probation. If a probationer commits an additional offense or violates a condition of probation, the court may issue a warrant for the defendant's rearrest, may modify or add probation conditions and may revoke probation. If probation is revoked while the defendant is serving more than one probationary term concurrently, the court may impose consecutive prison terms (A.R.S. § 13-901).

A DCAC is an enumerated offense committed against a minor who is under 15 years of age. The listed offenses include, among others, second degree murder, sexual assault, molestation of a child, sexual conduct with a minor, commercial sexual exploitation of a minor, sexual exploitation of a minor, specified child abuse, kidnapping, luring a minor for sexual exploitation and sexual extortion. A completed offense is a DCAC in the first degree and a preparatory offense is in the second degree (A.R.S. § 13-705).

Provisions

1. Requires, notwithstanding any other law, the court to issue a warrant for the rearrest of a defendant who is at least 18 years of age, who has been convicted of a DCAC and who commits an additional offense or violates a condition of probation. (Sec. 1)
2. Mandates that the court must revoke that defendant's probation in accordance with the Arizona Rules of Criminal Procedure at any time before the probation period expires or terminates. (Sec. 1)
3. Requires the court, if probation is revoked and the defendant is serving more than one probationary term concurrently, to impose the resulting terms of imprisonment consecutively. (Sec. 1)

☐ Prop 105 (45 votes) ☐ Prop 108 (40 votes) ☐ Emergency (40 votes) ☐ Fiscal Note

ARIZONA STATE SENATE

Fifty-Seventh Legislature, Second Regular Session

FACT SHEET FOR S.B. 1709

dangerous crimes; children; probation; revocation

Purpose

Requires, rather than allows, the court to issue a warrant for rearrest and revoke probation for a probationer who commits an additional offense or who violates probation conditions, if the probationer is at least 18 years old and is convicted of a dangerous crime against children (DCAC).

Background

If a person who has been convicted of an offense is eligible for probation, the court may suspend the imposition or execution of their sentence and must, without delay, place the person on intensive probation supervision or supervised or unsupervised probation on such terms and conditions as the law requires and the court deems appropriate, including participation in any community punishment programs. In its discretion, the court may issue a warrant for the rearrest of a defendant and may modify or add conditions to probation or may revoke probation if the defendant commits an additional offense or violates a condition. If the court revokes probation and the defendant is serving more than one probationary term concurrently, the court may sentence the person to serve the terms of imprisonment consecutively (A.R.S. § 13-901).

DCACs include various serious crimes and sexual offenses committed against a minor who is under 15 years old, including: 1) second degree murder; 2) aggravated assault; 3) sexual assault; 4) sexual conduct with a minor; 5) sexual abuse; 6) sex trafficking; and 7) luring and aggravated luring of a minor for sexual exploitation (A.R.S. § 13-705).

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

1. Requires a court, notwithstanding any other law, to issue a warrant for rearrest of a defendant and revoke the defendant's probation if the defendant commits an additional offense or violates a condition of probation and the defendant is at least 18 years old and convicted of a DCAC.

2. Requires the court, if it revokes a defendant's probation and the defendant is serving more than one probationary term concurrently, to sentence the person to serve the terms of imprisonment consecutively.

3. Becomes effective on the general effective date.

Prepared by Senate Research
February 13, 2026
ZD/ci

REFERENCE TITLE: dangerous crimes; children; probation revocation

State of Arizona
Senate
Fifty-seventh Legislature
Second Regular Session
2026

SB 1709

Introduced by
Senator Shamp

AN ACT

AMENDING SECTION 13-901, ARIZONA REVISED STATUTES; RELATING TO PROBATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 13-901, Arizona Revised Statutes, is amended to read:

13-901. Probation

A. If a person who has been convicted of an offense is eligible for probation, the court may suspend the imposition or execution of sentence and, if so, shall without delay place the person on intensive probation supervision pursuant to section 13-913 or supervised or unsupervised probation on such terms and conditions as the law requires and the court deems appropriate, including participation in any programs authorized in title 12, chapter 2, article 11. If a person is not eligible for probation, imposition or execution of sentence shall not be suspended or delayed. If the court imposes probation, it may also impose a fine as authorized by chapter 8 of this title. If probation is granted the court shall impose a condition that the person waive extradition for any probation revocation procedures and it shall order restitution pursuant to section 13-603, subsection C where there is a victim who has suffered economic loss. When granting probation to an adult the court, as a condition of probation, shall assess a monthly fee of not less than $65 unless, after determining the inability of the probationer to pay the fee, the court assesses a lesser fee. This fee is not subject to any surcharge. In justice and municipal courts the fee shall only be assessed when the person is placed on supervised probation. For persons placed on probation in the superior court, the fee shall be paid to the clerk of the superior court and the clerk of the court shall pay all monies collected from this fee to the county treasurer for deposit in the adult probation services fund established by section 12-267. For persons placed on supervised probation in the justice court, the fee shall be paid to the justice court and the justice court shall transmit all of the monies to the county treasurer for deposit in the adult probation services fund established by section 12-267. For persons placed on supervised probation in the municipal court, the fee shall be paid to the municipal court. The municipal court shall transmit all of the monies to the city treasurer who shall transmit the monies to the county treasurer for deposit in the adult probation services fund established by section 12-267. Any amount assessed pursuant to this subsection shall be used to supplement monies used for the salaries of adult probation and surveillance officers and for support of programs and services of the superior court adult probation departments.

B. The period of probation shall be determined according to section 13-902, except that if a person is released pursuant to section 31-233, subsection B and community supervision is waived pursuant to section 13-603, subsection K, the court shall extend the period of probation by the amount of time the director of the state department of corrections approves for the inmate's temporary release.

C. The court, in its discretion, may issue a warrant for the rearrest of the defendant and may modify or add to the conditions or, if the defendant commits an additional offense or violates a condition, may revoke probation in accordance with the Arizona rules of criminal procedure at any time before the expiration or termination of the period of probation. If the court revokes the defendant's probation and the defendant is serving more than one probationary term concurrently, the court may sentence the person to terms of imprisonment to be served consecutively.

D. At any time during the probationary term of the person released on probation, any probation officer, without warrant or other process and at any time until the final disposition of the case, may rearrest any person and bring the person before the court.

E. The court, on its own initiative or on application of the probationer, after notice and an opportunity to be heard for the prosecuting attorney and, on request, the victim, may terminate the period of probation or intensive probation and discharge the defendant at a time earlier than that originally imposed if in the court's opinion the ends of justice will be served and if the conduct of the defendant on probation warrants it.

F. When granting probation the court may require that the defendant be imprisoned in the county jail at whatever time or intervals, consecutive or nonconsecutive, the court shall determine, within the period of probation, as long as the period actually spent in confinement does not exceed one year or the maximum period of imprisonment allowed under chapter 7 of this title, whichever is the shorter.

G. If the defendant is placed on lifetime probation and has served one year in the county jail as a term of probation, the court may require that the defendant be additionally imprisoned in the county jail at whatever time or intervals, consecutive or nonconsecutive, the court shall determine, within the period of probation if the defendant's probation is revoked by the court and the defendant is subsequently reinstated on probation. The period actually spent in confinement as a term of being reinstated on probation shall not exceed one year or, when including the initial one-year period of incarceration imposed as a term of probation, the maximum period of imprisonment allowed under chapter 7 of this title, whichever is shorter.

H. If restitution is made a condition of probation, the court shall fix the amount of restitution and the manner of performance pursuant to chapter 8 of this title.

I. When granting probation, the court shall set forth at the time of sentencing and on the record the factual and legal reasons in support of each sentence.

J. If the defendant meets the criteria set forth in section 13-901.01 or 13-3422, the court may place the defendant on probation

pursuant to either section. If a defendant is placed on probation pursuant to section 13-901.01 or 13-3422, the court may impose any term of probation that is authorized pursuant to this section and that is not in violation of section 13-901.01.

K. If the court imposes a term of probation, the court may require the defendant to report to a probation officer. The court or the defendant's probation officer may allow the defendant to fulfill a reporting requirement through remote reporting. The probation officer shall take into consideration and make accommodations for the probationer's work schedule, family caregiver obligations, substance abuse treatment or recovery program, mental health treatment, transportation availability and medical care requirements before setting the reporting time and location requirements for the probationer.

L. If a probationer makes a written request to the supervising probation department to courtesy transfer the probationer's intensive probation supervision or supervised probation to another county in this state with the intent to reside in that county and provides proof of family caregiver obligations, employment or housing, or an offer of employment or housing that will assist in the probationer's positive behavioral change, the supervising probation department shall do all of the following:

1. Confirm the details of the probationer's employment, housing or family caregiving plans.

2. Review any victim safety concerns and ensure compliance with the victims' bill of rights.

3. Submit the request for permission to proceed to the receiving county within seven business days after receipt.

M. After verifying the information submitted by the sending probation department pursuant to subsection L of this section, the receiving probation department shall provide the sending probation department with permission for the probationer to proceed to the receiving county within seven business days after receipt unless the receiving probation department finds the basis for the plan is not factual or the transfer will endanger the victim.

N. If a probationer's intensive probation supervision or supervised probation is courtesy transferred to another county pursuant to subsection L of this section and the probationer subsequently violates the terms of the probationer's probation or commits an additional offense while on probation, the probation department in the county in which the probation violation or additional offense occurred may not return the probationer's intensive probation supervision or supervised probation back to the county in which the probationer's probation was originally imposed except for revocation hearings or an order of the court.

O. NOTWITHSTANDING ANY OTHER LAW, IF A DEFENDANT IS AT LEAST EIGHTEEN YEARS OF AGE, IS CONVICTED OF A DANGEROUS CRIME AGAINST CHILDREN

AND COMMITS AN ADDITIONAL OFFENSE OR VIOLATES A CONDITION OF PROBATION, THE COURT SHALL ISSUE A WARRANT FOR THE REARREST OF THE DEFENDANT AND SHALL REVOKE THE DEFENDANT'S PROBATION IN ACCORDANCE WITH THE ARIZONA RULES OF CRIMINAL PROCEDURE AT ANY TIME BEFORE THE EXPIRATION OR TERMINATION OF THE PERIOD OF PROBATION. IF THE COURT REVOKES THE DEFENDANT'S PROBATION AND THE DEFENDANT IS SERVING MORE THAN ONE PROBATIONARY TERM CONCURRENTLY, THE COURT SHALL SENTENCE THE PERSON TO TERMS OF IMPRISONMENT TO BE SERVED CONSECUTIVELY.

BACKGROUND MATERIAL

April 20, 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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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.

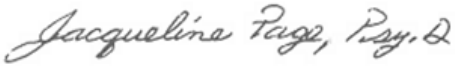
We thank the membership for their support throughout this process including taking the time to provide comments and feedback on the official draft during the membership review. We also thank the ATSA Executive Board of Directors for their careful review, response, and approval of the final document.

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:



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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 nonsexual 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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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).

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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