BACKGROUND MATERIAL

May 18, 2026

ADULT GUIDING PRINCIPLES

Adult Guiding Principles

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

1. The highest priority of these Standards and Guidelines is to maximize community safety[1] through the effective delivery of quality evaluation, treatment and management of sex offenders.

2. Sexual offenses are traumatic and can have a devastating impact on the victim and victim's family.

   Sexual offenses violate victims and can lead to common and serious consequences across all areas of victims' lives, including chronic and severe mental and physical health symptoms,[2] as well as social, family, economic, and spiritual harm.[3] Research and clinical experience indicate that victims of sexual abuse often face long-term impact and continue to struggle for recovery over the course of their lifetime.[4] The impact of sexual offenses on victims varies based on numerous factors. By defining the offending behavior and holding offenders accountable, victims may potentially experience protection, support and recovery.[5] Professionals working with sexual offenders should be alert to how offenders' behaviors may inflict further harm on persons they have previously victimized.[6]

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

[2] Chen et al. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*, 618-629; Dworking, E. R., Menon, S. V., Bystrynski, J., & Allen, N. E. (2017). Sexual assault victimization and psychopathology: A review and meta-analysis. *Clinical Psychology Review, 56*, 65-81; Mason, F. & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27*, 27-37; O'Leary, P., Easton, S. D., & Gould, N. (2017). The effect of child sexual abuse on men: Toward a male sensitive measure. *Journal of Interpersonal Violence, 32(2)*, 423-445; Pérez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: A national study. *Comprehensive Psychiatry, 54*, 16-17; Walsh et al. (2012). National prevalence of posttraumatic stress disorder among sexually re-victimized adolescent, college, and adult household-residing women. *Archives of General Psychiatry, 69(9)*, 935-942; Wilson, D. (2010). Health Consequences of Childhood Sexual Abuse. *Perspectives in Psychiatric Care. 46(1)*, 56-64.

[3] Dworking et al (2017); Mason et al (2017); O'Leary et al (2017); Pérez-Fuentes et al (2013).

[4] Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*, 225-246; Cuevas, C. A., Finkelhor, D., Clifford, C., & Ormrod, R. K. (2010). Psychological distress as a risk factor for re-victimization in children. *Child Abuse & Neglect, 34*, 235-243; Dworking et al (2017); Finkelhor, D. (2009). The Prevention of Childhood Sexual Abuse. *Future of Children, 19(2)*, 169-194; Mason et al (2017); O'Leary et al (2017); Pérez-Fuentes et al (2013).

[5] Whittle et al. (2015). A Comparison of Victim and Offender Perspectives of Grooming and Sexual Abuse. *Deviant Behavior, 36(7)*, 539-564.

[6] Hanson, R. K. & Yates, P. M. (2013). Psychological treatment of sex offenders. *Current Psychiatry Reports, 15(3)*, 1-8; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11*, 210-227; Patterson, D. (2011). The linkage between secondary victimization by law enforcement and rape case outcomes. *Journal of Interpersonal Violence, 26(2)*, 328-347; Watson, R., Daffern, M., & Thomas, S. (2017). The impact of interpersonal style and interpersonal complementarity on the therapeutic alliance between therapists and offenders in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment, 29(2)*, 107-127; Watson, R., Thomas, S., & Daffern, M. (2015). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*, 1-20.

3. Community safety and the rights and interests of victims and their families, as well as potential victims, require paramount attention when developing and implementing assessment, treatment and management of sex offenders.[7]

4. Offenders are capable of change.

   Responsibility for change ultimately rests with the offender. Individuals are responsible for their attitudes and behaviors and are capable of eliminating abusive behavior through personal ownership of a change process. While responsibility for change is the offender's, the therapeutic alliance between the offender and the therapist is a predictive and important facet of responsivity leading to behavioral change.[8] A warm, direct, and empathic therapeutic approach contributes to an offender's motivation to change, as does the supervising officer's positive working alliance with the offender. [9]

   The treatment and management of sex offenders requires a coordinated response by the probation and treatment team and will be most effective if SOMB providers and the entirety of the criminal justice and social services systems apply the same principles and work together.[10]

   Community safety is enhanced when treatment providers and community supervision professionals' practice in their area of specialization and work together. This collaboration should include frequent and substantive communication about information that will assist in reducing an offender's risk to the community. When the supervision and treatment members respect the individual roles and mutually agree upon their goals, the offender can be treated and managed more effectively. [11]

5. Community supervision is an opportunity, the success of which is dependent upon a sexual offender's willingness and ability to cooperate with treatment and supervision, and be accountable for their behaviors. [12] Accordingly, members of the supervision and treatment team should employ practices designed to maximize offender participation and accountability. [13]

[7] Campbell et al (2009); Cuevas et al (2010); Dworking et al (2017)

[8] Blasko, B., & Jeglic, E. (2014). Sexual offenders' perceptions of the client-therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment, 28*(4):1-20; Kozar, C. J. & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17,* 482-487; Watson et al. (2017); Watson et al. (2015).

[9] Kozar et al (2012); Labrecque, R. M., Schweitzer, M., & Smith, P. (2014). Exploring the perceptions of the offender-officer relationship in a community supervision setting. *Journal of International Criminal Justice Research, 1*, 31-46; Watson et al. (2017); Watson et al. (2015).

[10] Alexander, R. (2010). Collaborative supervision strategies for sex offender community management. *Federal Probation, 74(2),* 16-19; Palmiotto, M. & MacNichol, S. (2010). Supervision of sex offenders: A multi-faceted and collaborative approach. *Federal Probation, 74(2),* 27-30.

[11] Alexander (2010); Palmiotto & MacNichol (2010).

[12] Hönig, M., Vogelvang, B., & Bogaerts, S. (2017). "I am a different man now" - Circles of Support and Accountability: A prospective study. *International Journal of Offender Therapy and Comparative Criminology, 61(7),* 751-772.

[13] D'Orazio et al (2014); Woldgabreal, Y., Day, A., & Ward, T. (2016). Linking positive psychology to offender supervision outcomes: The mediating role of psychological flexibility, general self-efficacy, optimism, and hope. *Criminal Justice and Behavior, 43(6),* 697-721.

6. Treatment and supervision are most effective when they are individualized, and incorporate evidence-based and research informed practices. [14]

7. Risk for future sexual offending varies and may increase or decrease. The intensity and duration of treatment and supervision should respond to these variations in risk. [15]

   Individual assessment and evaluation of risk should be an ongoing practice. Treatment approaches and supervision plans should be modified accordingly. Effective management of risk balances the use of external controls with the development of individual protective factors and self-regulation in order to reduce risk, enhancing the offender's ability to live safely in the community.

8. Victims have the right to safety, to be informed and to provide input to the supervision and treatment team.

   Physical and psychological safety is a necessary condition for victims to begin recovery related to sexual abuse. Victims experience additional trauma when they are blamed or not believed, which may be more damaging than the abuse itself. [16] Victim impact is substantially reduced when victims are believed, protected and adequately supported.

   The supervision and treatment team can assist the victim in this by providing information and affording the victim representation in the supervision and management of the offender. Victim input and knowledge of the offender are valuable information for the supervision team. [17] Victims are empowered to determine their level of participation.

9. When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any conflicting parental or family interests.

[14] Gallo et al. (2014); Hanson, R. K., Bourgon, G., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders. *Criminal Justice and Behavior, 36(9)*, 865-891; Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression, 20(1),* 9-22; Seewald, K., Rossegger, A., Gerth, J., Urbaniok, F., Phillips, G. & Endrass, J. (2017). Effectiveness of a risk-need-responsivity-based treatment program for violent and sexual offenders: Results of a retrospective, quasi-experimental study. *Legal and Criminological Psychology, 23,* 85-99; Ward, T. & Gannon, T. (2014). Where has all the Psychology Gone: A Critical Review of Evidence-Based in Correctional Settings. *Aggression and Violent Behavior, 19*(4):435-446; Ward, T., Gannon, T., & Yates, P. (2008). The treatment of offenders: Current practice and new developments with an emphasis on sex offenders. *International Review of Victimology. 15(2),* 183-208.

[15] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), *What works in offender rehabilitation: An evidence-based approach to assessment and treatment* (pp. 71-93). Hoboken, NJ: Wiley-Blackwell; Gallo et al. (2014); Hanson et al. (2009); Parent, G., Guay, J., & Knight, R. (2011). An assessment of long-term risk of recidivism by adult sex offenders: One size doesn't fit all. *Criminal Justice and Behavior, 38(2),* 188-209; Seewald et al. (2017); van den Berg, J. W., Smid, W., Schepers, K., Wever, E., van Beek, D., Janssen, E., & Gijs, L. (2017). The predictive properties of dynamic sex offender risk assessment instruments: A meta-analysis. *Psychological Assessment,* 1-13.

[16] Beaver, W. R. (2017). Campus sexual assaults: What we know and what we don't. *The Independent Review, 22(2),* 257-268; Hayes, R. M., Abbott, R. L., & Cook, S. (2016). It's her fault: Student acceptance of rape myths on two college campuses. *Violence Against Women, 22(13),* 1540-1555; Littleton, H. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Dissociation, 11(2),* 210-227; Najdowski, C., & Ullman, S. E. (2011). The effects of re-victimization on coping in women sexual assault victims. *Journal of Traumatic Stress, 24(2),* 218-221; Paige, J. & Thornton, J. (2015). Healing from intrafamilial child sexual abuse: The role of relational processes between survivor and offender. *Children Australia, 40(3),* 242-259; Patterson, D. (2011). The linkage between secondary victimization by law enforcement and rape case outcomes. *Journal of Interpersonal Violence, 26(2),* 328-347; Rennison, C. M. & Addington, L. A. (2014). Violence against college women: A review to identify limitations in defining the problem and inform future research. *Trauma, Violence, and Abuse, 15(3),* 159-169; Ullman & Peter-Hagene (2016). Longitudinal relationships of social reactions, PTSD, and re-victimization in sexual assault survivors. *Journal of Interpersonal Violence, 31*6), 1074-1094; Yung, C. R. (2015). Concealing campus sexual assault: An empirical examination. *Psychology, Public Policy, and Law, 21(1),* 1-9.

[17] Center for Sex Offender Management (2007). The Role of the Victim and Victim Advocate in Managing Sex Offenders (training curriculum). Silver Spring, MD.

10. The AZSOMB is committed to creating Standards and Guidelines that are based on current and emerging research and best practices.

    Treatment, management, and supervision decisions should be guided by empirical findings when research is available. Since there is limited and emerging empirical data specific to sexual offending, decisions should be made cautiously to minimize unintended consequences.

11. A continuum of treatment and management options for sex offenders should be available in each community in the state. Additionally, efforts should be made to maximize continuity of care whenever a transition from one treatment setting to another to maximize positive treatment progress.

    It is in the best Interest of public safety for each community to have a continuum of management and treatment options so that treatment is appropriately matched to the client.

12. Successful treatment and management of sex offenders is enhanced when the supervision and treatment models and encourages family, friends, employers and other members of the community in pro-social support of the offender. [18]

    Families, friends, employers and members of the community who have influence in the lives of offenders can meaningfully contribute to their successful functioning in society. Family and friends should be included in the supportive network in a manner that is sensitive to the possible negative impact of the offense on them. [18]

13. Information sharing among supervision and treatment members is vital to public safety and offender success.

    Sexual offense-specific treatment is not conducted with the same degree of confidentiality as non-mandated treatment. [19] Sex offenders waive confidentiality with regard to therapeutic and/or public safety goals. When sensitive and private information is shared, the dignity and humanity of all involved must be respected.

14. Sex offense-specific assessment, evaluation, treatment, behavioral monitoring and supervision should be humane, non-discriminatory and bound by the rules of ethics and law. [20]

15. The individualization of evaluations, assessment, treatment and supervision requires particular attention to social and cultural factors. Recognition of these factors are essential when interacting with clients from different social, cultural, and religious

[18] Wilson, R., & McWhinnie, A. (2013). Putting the 'Community' back in community risk management of persons who have sexually abused. *International Journal of Behavioral Consultation and Therapy, 83-4), 72-79.*

[19] Levinson J. & Prescott, D. (2010), Sex offender treatment is not punishment. *Journal of Sexual Aggression, 16(3); 275-285;* McGrath et al. (2010). *Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey*. Brandon, VT: Safer Society Press; Sawyer, S. & Prescott, D. (2011). Boundaries and dual relationships. *Sexual Abuse: A Journal of Research and Treatment, 23(3)*, 365-380.

[20] Birgden, A. & Cucolo, H. (2011). The treatment of sex offenders: Evidence, ethics, and human rights. *Sexual Abuse: A Journal of Research and Treatment, 23(3)*, 295-313; Harrison, K. & Rainey, B. (2013). Legal and ethical aspects of sex offender treatment and management, Chichester, K, John Wiley & Sons, Ltd.

backgrounds. A basic premise is to recognize the client's culture, your own culture, and how both affect the client-provider relationship.

This premise extends to all professional members of the supervision and treatment team and positive support persons and is essential in creating an equitable and inclusive environment regardless of differences in culture or lifestyle.

BACKGROUND MATERIAL

May 18, 2026

JUVENILE GUIDING PRINCIPLES

Juvenile Guiding Principles

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

1. **The highest priority of these Standards and Guidelines is to maximize community safety through the effective delivery of quality evaluation, treatment and management of juveniles who commit sexual offenses.**[1]

2. **Sexual offenses are traumatic and can have a devastating impact on the victim and victim's family.**

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

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

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

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

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

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

[5] Briere & Scott (2006). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment. Thousand Oaks, CA: Sage Publications; Morrison (2007). Caring about sexual assault: the effects of sexual assault on families, and the effects on

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

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

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

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

6. **Treatment and supervision decisions should be informed by a comprehensive evaluation**[7] **and ongoing assessments.**[8]

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

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

victim/survivors of family responses to sexual assault. *Family Matters, 76*:55-63; O'Doherty, T., McLaughlin, S., Deirdre O'Leary, D. (2001). Recovery work with child victims of sexual abuse: A framework for intervention. *Child Care in Practice, 7*(1):78-88.

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

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

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

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

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

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

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

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

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

10. **Treatment and supervision should be individualized and responsive based on the juvenile's risks and needs.**[11]

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

11. **Evaluation, ongoing assessment, treatment and supervision of juveniles who have committed sexual offenses should be non-discriminatory, humane and bound by the professional code of ethics and law.**[12]

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

[10] Center for Sex Offender Management (2007). Enhancing the Management of Adult and Juvenile Sex Offenders: A Handbook for Policymakers and Practitioners. *Center for Effective Public Policy, U.S. Department of Justice, Office of Justice Programs*, 2005-WP-BX-K179 and 2006-WP-BX-K004; Center for Juvenile Justice Reform (2012). Addressing the Needs of Multi-System Youth - Strengthening the Connection between Child Welfare and Juvenile Justice, Georgetown Public Policy Institute, Washington, D.C.; Lobanov-Rostovsky, C. & Hansen, J. (2013).

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

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

12. **Assessment of the degree of progress in treatment is based on the juvenile's application of relevant changes in their daily functioning.**[13]

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

13. **Treatment should be holistic and enhance overall health and protective factors.**[14]

    Many juveniles who commit sexual offenses have multiple problems and areas of risk. Research indicates that juveniles are at greater risk for non-sexual re-offenses than for sexual re-offenses.[15] Assessment and treatment must address areas of strengths, risks and deficits to increase the juvenile's abilities to be successful and to decrease the risks of further abusive or criminal behaviors. Treatment plans should specifically address the risks of further sexual offending, other risks that might jeopardize safety and successful pro-social functioning.[16] Treatment plans should also reinforce developmental and environmental assets.

14. **Assessment, treatment and supervision should be viewed through an ecological framework of Development.**[17]

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

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

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

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

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

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

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

15. **Family members/Primary Caregivers should be considered an integral part of evaluation, assessment, treatment and supervision.**[18]

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

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

    Conversely, non-cooperative family members may impede the juvenile's progress.[19] It is expected that the MDT will work with the family/primary caregiver to help them support the juvenile through cooperative involvement.

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

    As juveniles move through the continuum of services emphasis should be given to maintaining positive and consistent relationships, including both in and out of a school setting. Research indicates that association with delinquent peers, the absence of pro-social adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.[20]

17. **A continuum of care for treatment and supervision options should be available and utilized as needed.**[21]

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

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18. **For juveniles who have been removed from the home family reunification can only occur after careful consideration of all the potential risks.**[22]

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

19. **Juveniles shall not be labeled as if their sexual offending behavior defines them.**[23]

    It is imperative in understanding, treating and intervening with juveniles who commit sexual offenses to consider their sexual behavior in the context of the many formative aspects of their personal development. As juveniles grow and develop their behavior patterns and self-image constantly change. Research suggests that most juveniles will not go on to offend sexually as adults.[24] Not all juveniles who have engaged in sexually abusive behavior require extensive or intensive interventions in order to reduce their risk for reoffending because identity formation is a significant developmental task during adolescence, labeling juveniles based solely on sexual offending behavior may cause potential damage to long-term pro-social development.

20. **Successful completion of treatment and supervision depends upon a juvenile's willingness and ability to cooperate. Accordingly, members of the MDT should employ practices designed to maximize the juvenile's participation and accountability.**[25]

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