The Utah Network on Juveniles Offending Sexually

ADOLESCENT TREATMENT/PLACEMENT PROTOCOL AND STANDARDS MANUAL

Sixth Edition

Adolescent Treatment / Placement Protocol

Revised September 2016

With Thanks

The efforts of many individuals who work tirelessly with adolescents and children who have sexually offended have gone into writing this manual and then updating it through the years. Without the passion and commitment of these individuals, NOJOS would not exist. Thanks to each and every person who had contributed to this and earlier versions of this manual.

NOTE

The Network on Juveniles Offending Sexually (NOJOS) has been actively involved in developing standards for the treatment of individuals who sexually harm others for decades, with the first standards manual being produced in 1994. This manual is updated as new research indicates. The desire is to keep the standards in line with national best practice standards, and research and evidence-based outcomes. The latest update integrates both of these with the goal of giving those individuals involved the best possible, most healthy outcome.

Among the members of the NOJOS community, there is some controversy about whether to stay true to the "Juveniles who Offend Sexually" or to go to the "Juveniles with Sexual Misconduct." Emotions can be strong with each group. Those who use "juveniles who offend sexually" do so to reflect the harm caused to those who are abused and can feel that using the word misconduct falsely minimizes the pain and harm that is caused by the behavior. Those who use the word "misconduct" do so to reflect the hope there is for the individuals treated as well as to avoid the stigma of labeling. While the term misconduct reflects this important non-punitive point of view, misconduct can also be used for a wide range of sexual behaviors that might not be harming to others. Use of the term "offending" or "abusing" can confuse the behavior of adolescents with that of adults and there is much research to reflect that adolescent who sexually harm usually do not go on to offend sexually as adults.

No matter which term is used, the members of the NOJOS community agree, both through research and evidence-based practice, that individuals who have sexually harming behavior while children or adolescents can and do grow up to be successful, fully functional and happy individuals and they do not need punitive and shaming labels that follow them into adulthood and interfere with that ability to be happy and successful.

PROTOCOLS AND STANDARDS
FOR YOUTH WHO ENGAGE IN SEXUAL MISCONDUCT

ADOLESCENT TREATMENT / PLACEMENT

Table of Contents

Best Practice Standard in Treating Youth Who Engage in Sexual Misconduct

The standards in this manual represent the best practices as measured by current research, evidence-based practice and outcome measures. Goals include promoting healing, forgiveness, and respect for self and others. The best practitioners are warm and empathic, addressing all aspects of the youth's functioning, while maintaining a focus on those areas demonstrated to be associated with risk. Interventions that do not take the youth's family circumstances into consideration may well do harm in the long run.

The sex- specific treatment approach must be sensitive to the youth's developmental trajectory and how experience, development, environment, differing ability, society, and culture impact this trajectory and create dynamics, issues, and problems that placed the youth on a pathway to sexually offend.

"We do not know exactly what variables need to be present, in what combinations, in what relationships to each other, at what critical points of development, with what intensities, and in what context, in order for sexual abuse to occur and be maintained" (Thomas 2006). However, what is clear is that sexual acting out is a result of multiple, interacting factors (etiological and maintenance factors) that converge at a particular point in time in a given context. These factors "have a cumulative effect" on the youth (Prescott 2006) diverting their normative path of development. It is about the convergence and melding of these factors that creates a synergistic reaction (Ward, Polaschek, and Beech, 2006). Etiological and maintenance factors include: disruption and deficits in development, inconsistent and unhealthy environments, deficits in executive functioning and problems with self-regulation, cognitive distortions and underdeveloped values and morality, problems in emotional identification, expression and regulation, problems and deficits in self-concept, self-esteem and self-identity, social competency and social relatedness problems, childhood trauma and maltreatment, awareness deficits and other co-morbid mental health issues and learning disabilities.

Sex-specific assessment should help identify which factors, in what proportion, and at what point in development, youth were directed onto the pathway to offending. Additionally, treatment should assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate the etiological and maintenance factors that influenced their pathway to offend, to re-establish a healthy developmental trajectory (in all developmental stages), to obtain their needs and human goods in a healthy way and to place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T., Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

National literature endorses the use of a holistic, integrated approach to treating youthful sexual abuse (Longo, 2001; Hunter & Longo, 2004). This approach blends traditional aspects of sexual-abuse treatment into a holistic, humanistic and developmentally-consistent model for working with youth. While cognitive-behavioral treatment methods appear promising, treatment must go beyond the sexual problems and address "growth and development, social ecology, increasing health, social skills, resiliency, and incorporate treatment for the offender's own victimization and

co-occurring disorders" (Developmental Services Group, 2000). Protective Factors can have a great impact on decreasing risk and helping the youth in making healthy life choices (J. Worling, 2013, DASH).

The primary aim in juvenile sex-specific treatment is to instill in the youth the knowledge, skills and competencies necessary to develop and implement a positive and healthy identity revolving around personally meaningful ways of meeting their human needs and pursuing their interests. Thus, treatment is focused on factors related to the youth's developmental trajectory—the causal and maintenance factors that diverted the youth to a pathway to offend.

Treatment interventions need to help the youth to successfully re-enter a healthy developmental trajectory and build the competency, resiliency, and protective factors necessary to resolve and/or eliminate etiological and maintenance factors that led them to offend.

According to the "Good Lives Model," treatment should help the youth acquire (in a healthy way) the skills and primary human goods (healthy living, knowledge, excellence in play and work, excellence in self-agency, freedom from emotional turmoil and stress, friendship, community, purpose in life, happiness and creativity) required to be happy and healthy and live a good life (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006, page 297-313).

As part of a holistic approach, treatment should integrate standard sex-offense- specific treatment components, such as development of full accountability for all offense behaviors, insight into offense dynamics and choice to offend, building realistic and effective self-regulation strategies and skills, develop a family safety plan, develop healthy sexual attitudes, boundaries, impulse control, sexual identity, and develop and sustain victim empathy and general empathy. Treatment should also include sex education and healthy sexuality skills. A psychosexual education emphasis is needed to provide the youth with information regarding maturation, human development, healthy sexual functioning, the current laws regarding sexual conduct, the elements of consent and a healthy sexual identity. Many of these youth also need opportunities to resolve their own childhood victimization with interventions apart from the focus on their sexual misconduct to assist them to resolve trauma, enhance emotional coping skills and develop a healthy sexual identity. Overall, treatment is about aiding these youth to understand themselves, their sexuality and sexual development, as well as own responsibility for their sexuality (thoughts, feelings, and behavior), further identifying that there are consequences for their choices, and develop competencies and skills to enter or reenter a normative developmental pathway for their sexuality and life.

While NOJOS philosophy supports the holistic treatment of adolescents and children who have sexually offended, NOJOS also supports the needs of those who experienced abuse and all treatment decisions will honor the healing of both those who sexually offended and those who were offended against.

Understanding and Utilization of the Risk, Need, and Responsivity Model

A holistic approach to treatment should also demonstrate an understanding that the majority of any "re-offense" issues are criminal misconduct in nature, so there is a need to understand and integrate the elements of the Risk, Need, Responsivity Model (RNR) (Andrews & Bonta, 2010). The premise of this theoretical model supports the NOJOS position of levels of treatment based on risk to avoid the contagion effect of mixing risk levels of youth. By understanding the **Risk Principle** or the specific risk level a youth is to re-offend helps us delivered more treatment services to those youth of higher risk levels. The **Need Principle** focuses on clinicians/providers understanding the major dynamic risk/need factors that may lead to further criminal recidivism. The main focus is then, through treatment, developing these into protective factors, thus reducing risk. By targeting these in conjunction with sex-specific treatment goals gives a common language amongst professionals, provides targeted treatment for issues most likely to be involved in criminal recidivism, and support the concept of "holistic treatment. Although individual "treatment needs/targets" may vary, they can be found within the general domains of school, use of free time, employment, relationships, current living arrangements, alcohol/drugs, mental health, attitudes/behaviors, and skills. Often these areas closely match the human goods of the Good Life's Model. Lastly, the **Responsivity Principle** focuses on two primary targets: 1) General Responsivity, or the use of cognitive-behavioral, behavioral, and social learning interventions including modeling, role playing, and skill building; and 2) Specific Responsivity, which targets the individual client's personal factors or characteristics that need to be taken into consideration as interventions are tailored to these factors so help them engage in the treatment process or respond to the treatment process more favorably. (i.e. - age, maturity, interests, learning style, need for structure, or provider qualities like patience, being firm but fair, etc.) Use of the RNR Model helps provide a conceptual framework to conceptualize treatment needs, provides a focused common language and targets for treatment in conjunction with sex-specific interventions, and ultimately better holistic treatment and outcomes for youth. In summary, while we respond to risk and needs, a focus on the response of clients should include a focus on their strengths and building of protective factors. (Andrews, D.A.; Bonta, J. The Psychology of Criminal Conduct, 5th Edition, Anderson Publishing, 2010).

NOJOS Certification and Training

Sex-specific NOJOS treatment is a structured, multi-modal, multi-systemic, skill-based treatment. This treatment works best when it is relationship-based and is provided in a developmentally-sensitive, empathetic, warm, rewarding and directive environment. NOJOS also recognizes that these youth (when removed from their home and community) can be successfully reunified with their families/victims. However, to accomplish this, providers must assist youth in learning to generalize the skills they have developed into their family system as well as the community. This is accomplished through well-designed aftercare programs. NOJOS also understands that youth get healthier more quickly, and positive treatment progress occurs, with the inclusion of the youth's family in all aspects of assessment and treatment. Best practice sex-specific treatment is holistic, and it recognizes work with youth who engage in sexual misconduct is even more complex than traditional therapeutic approaches, as it deals with developmental and cognitive issues, personality development, family and community systems, a complex interplay between developing emotions and behaviors, the line between normative sex play and experimentation and the development of sexually abusive behaviors, psychiatric co-morbidity, social learning, and often the echoes of personal trauma in the youth (Rich, Phil. (2003); Understanding, Assessing, And Rehabilitating Juvenile sexual offenders; John Wiley & Sons, Inc., Page 4).

Clearly, the treatment of adolescent sexual issues is specialized and differs from generic mental-health treatment approaches. Indeed, "treatment requires a specially skilled clinician and clinical approach;" thus a "high level of therapist skill for clinicians working with youthful offenders is paramount" (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006, page 324). Accordingly, sex-specific treatment should be provided by NOJOS Certified Clinicians who have additional training and experience in working with juveniles, sexual abuse and sexual issues.

NOJOS Clinical Certification Requirements

1. Applicant must have a master's or doctoral degree in social work, psychology, marriage and family therapy, counseling, educational psychology, or other mental-health field from a fully-accredited college or university, or a psychiatric nurse or a medical doctor if the individual is a board certified/eligible psychiatrist.

2. Clinical Status Applicants must have a current license from the Division of Professional and Occupational Licensing. Licensure should be in the mental-health field (i.e. psychiatry, psychology, licensed professional counselor, social work, or marriage and family therapy).

3. Within the three-year period immediately preceding this application, the applicant must have at least 2000 hours of direct, clinical contact in a sex-offender treatment program. Direct clinical contact is defined as a licensed/supervised mental health professional providing sex-specific therapeutic intervention to persons who have sexually offended, been offended on, and/or those whose lives have been impacted by sexual offending. Indirect clinical contact is defined as any activities, tasks, information gathering or related endeavors that will assist the provider. For example, case supervision, case staffing, file

maintenance, session notes, attending or providing training, case coordination, publishing, and research). Included in the 2000 hours, there must be at least 1500 hours of direct clinical client contact, such as, individual, couples, group and/or family therapies.

4. Within the three-year period immediately preceding this application, the applicant must have completed a minimum of forty hours of formal sex offender-specific training through documented conferences, symposia, seminars or course work directly related to the evaluation and treatment of sex offenders. (The NOJOS Training Academies, NAPN, ATSA conference trainings meet the majority of the requirements.)

5. Clinical Status Applicants must have as a basic philosophy that comports with guidelines established by the National Adolescent Perpetration Network, the Association for the Treatment of Sex Abuses, and the NOJOS Adolescent Treatment/Placement Protocol and Standards Manual.

6. Clinical Status Applicants must adhere to the child abuse reporting laws as required by the Utah State Department of Human Services and the State of Utah.

7. Clinical Status Applicants may supervise a maximum of three Affiliate Status providers.

8. All service providers who change from one program to another must update their application within sixty days of the change in order to maintain the credential status.

9. Criminal convictions or licensure actions prior to this application must be disclosed and may result in the application be denied. Failure to disclose any current or future criminal convictions or licensure actions may result in termination of any approved status (See www.nojos.org).

Treatment / Placement Philosophy

Placement decisions are the most important decisions in balancing the juvenile's risk to re-offend (community protection/abuse prevention) and the need to help the juvenile develop in a manner that increases the likelihood of a positive adult lifestyle. Youth should be placed in the *least-restrictive environment* necessary to reduce/minimize risk and provide adequate treatment to facilitate positive growth. Risk-management practices must match the risk level of the juvenile who sexually offended. According to national standards, treatment is most effective when the intensity of services match the youth's risk and need (see RNR section). Providing an inappropriate level of service may negatively affect a youth's risk, rehabilitation and community protection. Thus, accurate risk assessment is a prerequisite to determine appropriate parameters needed for risk management and rehabilitation.

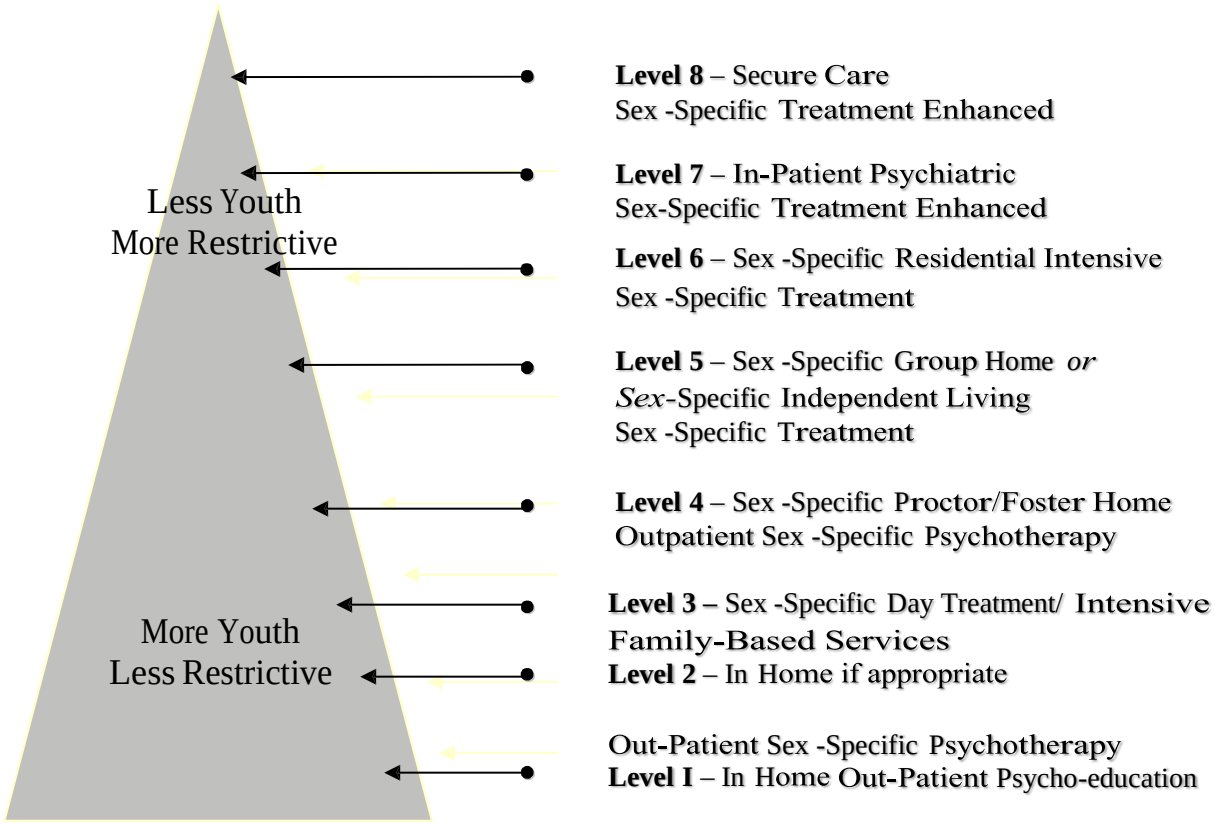
Community protection and healthy lifestyle is achieved through a continuum of eight levels of sex-specific treatment and supervision from least restrictive in-home intervention to secure care confinement. The continuum of services should allow movement up or down the continuum based on progress or regression in treatment. All agencies within the NOJOS continuum should have a common treatment philosophy and sex-specific best practices, which facilitates a continuity of care and seamless transition(s) as the juvenile moves up or down the continuum. Clinicians, probation officers and case managers should always recommend the optimal level of care needed, <u>even if it is not available,</u> for a specific client and then offer realistic alternatives documenting when the alternatives are less adequate.

It is imperative mental-health and juvenile-justice professionals work in a closely-coordinated manner to develop a comprehensive and individualized case-management plan. The integrated plan of services should be aimed at both maximizing community safety and ensuring that the youth and his/her family/care takers are given the intervention services they need. Additionally, and perhaps most importantly, sex-specific treatment along the continuum should be based on a *holistic approach* that addresses an integration of the entire functioning, context/family system and long-term development of each youth and person victimized.

The NOJOS Continuum

Sexually abusive youth are best rehabilitated with a continuum of care and services.

The NOJOS Continuum consists of the following eight levels, beginning with the least restrictive "Level One" to most restrictive "Level Eight" as follows:



1. 1. The placement should

Continuum of Care

1. The placement should correspond to the risk level and need level of the client.
2. The risk and need should be measured by examining the client's impulse control, protective factors and, with the possible exception of NOJOS Level I, through a sexual behavioral risk assessment.
3. Whenever legally possible, movement along the continuum should be based on the competency and safety level achieved by the client as well as the client's specific need
4. Initially, clients can be referred to any level of the continuum that corresponds to their diagnosed level of risk; however, decisions regarding movement to less restrictive placements should be competency based.
5. The entire continuum of care should use the same sex abuse-specific assessment and treatment criteria. While specific placements may emphasize different aspects of sex abuse-specific treatment, all placements should adhere to the outcome and research-based best practice standards. Sex abuse-specific treatment that takes place in other than outpatient settings, i.e., residential or day programs, should incorporate sexual abuse-specific milieu treatment. As such all staff in those placements should be trained:
    a. to provide abuse-specific interventions as part of their work with youth;
    b. to integrate the basics of abuse specific treatment into interventions that do not involve sexually abusive behaviors; and
    c. to integrate abuse-specific issues into vocational and educational curricula.
    d. Programs (non-outpatient settings, i.e., residential or day programs) offering specialized assessment and specialized groups, but do not provide specialized milieu treatment, should not be considered sex abuse-specific programs.
6. Whenever possible, caregivers should remain consistent as a youth moves from one level of the continuum to another (i.e., probation officer, case worker, therapists).
7. Placements along the continuum should be evaluated:
    a. by professionals trained in both evaluation methodology and abuse specific assessment and treatment; and
    b. according to sex abuse specific criteria agreed to in advance by evaluators and those being evaluated.
8. The continuum should include long-term self-help and require community safety and healthy living components.
9. Day programs and educational placements should be thoroughly integrated into the continuum of care and be required to provide sex abuse specific treatment.
10. All youth placed in programs anywhere along the continuum should receive pre- and post-placement evaluations. These evaluations should be the basis for initial placement and for discharge to less restrictive settings. These evaluations should also screen the client according to more traditional clinical criteria (i.e., thought disorders, clinical depression, ADHD, and other neurological criteria). (See Assessment Protocols and Standards section.)

In Home Placement should be considered when:

- It is in everyone's best interest;
- The juvenile is a relatively low risk offender;
- The juvenile is likely to comply with supervision;
- Treatment services are in place; and
- It is in the best interest of the person(s) who have been victimized.

In Home Placement should not be considered when:

- A history of severe abuse in the home by offender or others;
- The family is unwilling or unable to monitor risk;
- A history of repetitive assaults in the home despite prior interventions; and/or
- An unacceptable risk of reoffending and access to potential victims in the home or neighborhood.

In Home Placement should not be considered when:

- Signs of sexual deviance and access to victim or victim-type in the home;
- It would be detrimental to the victim in the home;
- Substance abuse by offender or others; and/or
- Other factors that clearly indicate that risk cannot be managed in the home environment

(Coffey, Patricia, Ph.D., *Forensic Issues In Evaluating Juvenile Sex Offenders*, Risk Assessment of Youth Who Have Sexually Abused, Prescott, David S., LICSW, Wood & Barnes Publishing, 2006, page 80-81).

Sex-Specific Treatment Goals:

Providers offering treatment to youth with sexual behavioral problems should ensure treatment addresses these goals. The following is a list of seventeen specific treatment areas identified as important in sex-specific treatment and rehabilitation:

1. Personal responsibility for behaviors;
2. Behavioral self-control, including interruption of patterns of dysfunctional behavior;
3. Pro-social behavior with the concomitant reduction of antisocial behavior;
4. Rational thinking and healthy attitudes, recognizing and eliminating cognitive distortions and attitudinal mind-sets that support sexually abusive behavior;
5. Healthy and appropriate self-expression;
6. Healthy and appropriate relationships with both peers and adults;
7. Improved self-esteem and sense of personal identity;
8. Improved mental health with resolution of co morbid psychiatric conditions;
9. Addiction-free lifestyle with regard to both addictive and compulsive sexual behaviors and substance use;
10. Intellectual improvement and development, recognizing and addressing cognitive impairments and developmental delays where present;
11. Healthy sexual attitudes, fantasies, and identity and the reduction or elimination of deviant (inappropriate) sexual arousal;
12. Trauma resolution in the event of personal victimization in the youth's own history;
13. Improved social skills and increased social competence and sense of self-efficacy and social mastery;
14. Development of relapse prevention plans that recognize situational, emotional, and cognitive factors that might contribute to a sexual re-offense, as well as defined methods to avoid high-risk situations and escape patterns of sexually inappropriate or otherwise antisocial behavior;
15. Improved family functioning in which family dysfunction, communication, attitudes, or roles contributing to or helping to maintain sexually aggressive, antisocial, or unhealthy behaviors are addressed and remediated;
16. Victim recognition and awareness with focus on the development of empathy and clarification of the harm caused to the victim and others;
17. Victim and community restitution in which the juvenile (sexual offender) undertakes reparation and "makes amends."

To operationalize the aforementioned goals, each youth should achieve the following nine concrete objectives:

1. Understand, identify, and interrupt thoughts, feelings, beliefs and behaviors that contribute to abuse and all unhealthy choices and behaviors;
2. Develop responsibility for personal choices and behavior without minimization or justification;
3. Understand the impact of past trauma on self-image, functioning, difficulties and behaviors;
4. Develop awareness, sensitivity and compassion for others;
5. Learn and understand normative and inappropriate and/or unhealthy sexual

development;

6. Identify, interrupt and control unhealthy and/or inappropriate sexual arousal, thoughts and fantasies;
7. Learn and use adaptive coping and social skills;
8. Build and engage in non-coercive relationships;
9. Develop and use healthy interventions and life skills to allow youth to successfully re-enter a healthy developmental trajectory and build the competency, resiliency and protective factors necessary to resolve and/or eliminate etiological and maintenance factors, as well as achieve (in a healthy way) the needs and goods required to be happy and healthy and live a good life.

(Adapted from Rich, Phil, *Evaluation of Juvenile Sexual Offender and the Assessment of Risk*, Understanding, Assessing, and Rehabilitation Juvenile Sexual Offenders, John Wiley & Sons, Inc., 2003.)

Clarification and Reunification

When a youth is removed from his/her home due to sexual misconduct, all contact and communication should only occur under clinical supervision and should adhere to a structured protocol. Re-establishing communication and contact should occur only as a therapeutic decision. Reunification decisions should be well thought out, clinically-guided and justified.

The following requirements are insisted upon and need to be followed during clarifying, resolving, reunifying youthful offenders with their victim(s), families and communities:

- The Clarification/Reunification process must be conducted and supervised by professionals skilled in working with sexual abuse treatment and dynamics.
- The sexually abusive youth, victim and all other participants must be assessed to determine if appropriate and if they can benefit from the process.
- The timeframe of when it should occur needs to be assessed. It is highly recommended that all individuals impacted or traumatized by the abuse should be involved in treatment during the clarification/reunification process.
- All participants should be carefully prepared.
- Any communication between sexually abusive youth and victim(s) needs to be clinically facilitated, approved and monitored.
- All goals and interventions need to be focused on the needs and best interest of the victim(s), families and community.
- Clear goals and objectives should be established prior to any/all communication between sexually abusive youth and victim(s).
- Rights, feelings and desires of the victim and those impacted by the abuse are paramount and take first priority throughout the process.
- Rules for behavior and communication should be established to ensure the physical and emotional safety of the participants.
- The victim may cancel the communication at any time and for any reason. Victim comfort and sense of control must be maintained during all sessions.
- Debriefing and follow-up with the therapists and the group members are integral elements of the process for all participants.
- It is acceptable and appropriate for the victim to change his/her position from one communication to the next and to change his/her mind about anything that transpired during any previous communication.
- Communication must be cancelled, postponed, terminated and/or re-evaluated if they appear to be causing any re-victimization or harm to the person victimized.
- The clinician should remain tuned into any subtle intimidation or pressure on the victim, whether intentional or unintentional, by the sexually-abusive youth or other family members, including parents.
- Enough time is provided in each communication to cover all material relevant to that session.
- Communication is scheduled frequently enough to ensure that the victim clarification process moves along smoothly.

(Lamb, D. et al., *The NOJOS Resolution Continuum With Traumatized Children, Families, And Communities Through Clarification, Resolution, Reintegration, And Reunification With Perpetrators Of Abuse:* a step-by-step guide to clinical reunification of abuse survivors, families, communities, and offenders impacted by abuse, 2003; Shladale, J., *A Collaborative Approach For Family Reconciliation And Reunification With Youth Who Have Caused Sexual Harm*, Knowledge & Practice-Challenges in the Treatment and Supervision of Sexual Abuses, Prescott, D.S., LICSW, Editor and Contributor, Wood 'N' Barnes Publishing, 2007, pages 239-279.)

Protocol and Standards for Conducting Juvenile Sex-Specific Assessments

Introduction

Juvenile sexual misconduct or sexually abusive behavior is highly idiosyncratic. There simply is no "one-size-fits-all" method for understanding this complex phenomenon (Rich, 2012). Similarly, there is no single approach or set of interventions utilized in sex-specific treatment for every case In part, this is due to the differing factors that influence youths to engage in sexual misconduct and the fact that the behavior occurs during the dynamic adolescent stage of development; nevertheless, professionals conducting juvenile sex-specific assessments should be directed by a standard of care based on best practices known today for managing and assessing juveniles who engage in sexual misconduct and sexually abusive behaviors. In fact, professionals are obligated to stay informed of current practice and research in their field. Accordingly, these standards should not stand alone, but must be read in conjunction with current national standards and guidelines for the assessment, treatment, and supervision of juveniles who engage in sexual misconduct or sexually abusive behaviors (e.g. Association for the Treatment of Sexual Abuses, National Adolescent Perpetration Network).

Sexual misconduct or sexually abusive behaviors may be motivated by a variety of factors unique to each youth that diverted his or her developmental pathway. For this reason, it is crucial to identify and assess as many of the underlying factors influencing the youth to engage in such conduct. For example, sexual behavior motivated by deviant sexual interests or a desire to harm others is significantly different than sexual behavior motivated by social deficits, a limited knowledge of sex in general, or cognitive delay. Thus, although the sexual behavior may appear to be the same, the underlying intentions are profoundly different, which in turn suggest different levels of risk and possibly different recommendations for treatment and supervision needs. Hence, the purpose of the sex-specific assessment must identify the individual intentions and motivations that underlie the youth's inappropriate conduct. Overall, developmentally-based, sex-specific assessments have the primary goal of understanding *that* individual in the context of his or her individual developmental path toward offending.

Standard of Care

A *Standard of Care* requires a professional to use the degree of skill and care of a reasonably competent practitioner in his/her field under same or similar circumstances. Accordingly, the NOJOS Protocol and Standards for Conducting Juvenile Sex-Specific Assessments (hereafter "NOJOS Assessment Protocol") includes current research and literature from experts in the field as well as recommended procedures of two national standard setting organizations who work with youth who engage in sexual misconduct and sexually abusive behaviors: The Associations For the Treatment of Sexual Abuses (ATSA) and The National Adolescent Perpetrator Network (NAPN). Overall, NOJOS Assessment Protocol represents the best practice standards known today for the assessment of juveniles who have engaged in sexual misconduct and/or sexually abusive behavior.

Practice Standards and Guidelines

Practice guidelines are established to outline the minimum standards necessary for practicing in a competent manner. These are not the "gold standard" for sexual evaluation and certainly do not include all proper or recommended methods for these types of assessments. However, they do represent a minimal standard by which a competent assessment should be completed. Ultimately, the clinician will use proper judgment in completing the assessment using the clinical data available, but should use these components as a base.

It is important to understand the purpose of the assessment, which will in turn determine the assessment type. Typically, assessments are requested for forensic purposes, such as disposition, for release from detention, placement, treatment, or supervision. One must consider that the assessment is much more than simply a risk assessment, as there are inherent gaps in the risk assessment instruments and they cannot be used as "stand alone" measures. These risk assessment instruments should be limited in their use when making forensic decisions such as placement. Clinical understanding of the juvenile's social and sexual history and other risk factors is imperative.

When completing a sexual assessment, the clinician should not only consider the reason for assessment (e.g. sentencing, treatment recommendation, determination of safety, etc.), but also the audience (e.g. parent, court, school district, etc.), and the timeline of intervention (e.g. pre-treatment, mid-treatment, post-treatment). The focus of the assessment will alter the format of the assessment. For example, it is ideal to re-assess the youth every six months of treatment; however, this re-assessment will not likely be as comprehensive in regard to social history and may not need the psychological evaluation component. Also, an assessment written for a parent of an offender may not include direct victim information, as this could breech confidentiality of the victim.

As Phil Rich (2009) indicates, the assessment should consider a risk construct as to whom is at risk, at risk for what, and at risk under what circumstances. Additionally, it is important to assess why the juvenile sexual offender is likely to engage in sexually abusive behavior again. Rich further asserts that one should assess what the risk is within the individual as compared to within the community. Rich notes: "The process of assessing risk, then, is based on understanding the youth in the context of his or her life and through the most detailed possible understanding of the individual." (p 30) He discusses the concepts of clinical versus actuarial assessment, meaning using multiple sources of data versus actuarial data collection only. Rich concludes that the risk assessment must be embedded within a more comprehensive assessment. He recommends assessing the juvenile sexual offender's social history, current functioning and mental health, and risk factors, as well as gaining parent input, collateral information about the offenses and the youth, and psychiatric and educational assessment. Clearly, Rich indicates a need for a comprehensive assessment to properly determine risk concerns and treatment needs.

Prescott (2006) makes clear the methods of assessment. Clinical assessments are made by clinicians, not necessarily using objective measures. Empirically guided assessments follow a structured interview or protocol. Actuarial assessment is a "… explicit and fixed method for arriving at a conclusion". (p 31) Prescott also describes using clinically adjusted actuarial assessment as a means of tailoring the assessment process and level of risk to the overall picture of the juvenile sexual offender while basing the risk on the actuarial means. Both Rich and Prescott favor use of actuarial assessment in combination with clinical assessment. Overall, comprehensive assessment is the best practice.

Worling and Curwen (2001) suggest a concise set of guidelines [adapted from Boer et al. (1997)] in regard to using the ERASOR; these guidelines certainly would apply to sexual assessment in

general. They indicate that evaluators should have training and expertise regarding the assessment of adolescents and their families, the assessment and management of sexual perpetration, and the existing research regarding adolescent sexual recidivism. They instruct that the assessor consider multiple domains of functioning, and use multiple methods of data collection, gain collateral information. Furthermore, according to Worling and Curwen, assessors should recognize the validity of the information they are given, state reservations, and update the report of risk factors upon changes in the youth's situation.

Proper and full assessment is imperative, as often sexual assessments are the basis for determination of treatment and placement. The NOJOS Protocol and Standards Manual (2007) indicates:

"Placement decisions are the most important decisions in balancing the juvenile's risk to reoffend (community protection/abuse prevention) and the need to help the juvenile develop in a manner that increases the likelihood of a positive adult lifestyle (rehabilitation). Youth should be placed in the least-restrictive environment necessary to reduce/minimize risk and provide adequate treatment to facilitate positive growth. Risk-management practices must match the risk level of the juvenile offender. According to national standards, treatment is most effective when the intensity of services match the youth's risk of recidivism. Providing an inappropriate level of service may negatively affect a youth's risk, rehabilitation and community protection. Thus, accurate risk assessment is a prerequisite to determine appropriate parameters needed for risk management and rehabilitation." (p. 9)

Therefore, the following practice guidelines are offered as a means to direct the clinician with the minimum industry standards needed to complete sexual assessment.

Additionally, it is recommended that the reader refer to these additional resources for further guidance in conducting sexual assessment:

> *National Task Force on Juvenile Sexual Offending, 1993 of the National Adolescent Perpetrator Network* (National Council of Juvenile and Family Court Judges);
>
> *Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices (*The Association for the Treatment of Sexual Abuses, 2012);
>
> *Ethical Standards and Principles of the Management of Sexual Abuses* (The Association for the Treatment of Sexual Abuses)

Developmental Aspects of Juveniles Who Engage in Sexual Misconduct

Different policies and standards are required for children and adolescents who engage in sexually abusive behavior from their adult counterparts because of the significant differences in "…particularly rapid and continuing adolescent development and dependence on adults and caregivers." (Hanson, Bourgon, Helmus & Hodgson, 2009, p 1). Moreover, adolescents who sexually offend are diverse, in age and maturity level, learning styles and challenges, and risk factors for reoffending. Effective policies and practices account for differences in risks, needs, and intervention responsivity among these youth.

For this reason, definitions of sexual behavior from children under the age of 12 and adolescents age 12 and older are provided. It is clear that a 17-year-old youth is developmentally different than

an 11-year-old youth. Developmental considerations and maturity are paramount in assessment and treatment.

Sexual Behavior in Children Age 12 and Younger

Developmentally expected sexual behavior is different than sexual victimizing behaviors or sexual misconduct per se. According to ATSA (2011), normal children engage in a wide variety of sexual behaviors. Johnson and Doonan (2006) purport that many children engage in behaviors that relate to "sex" but these are not necessarily sexualized in the sense one would consider such behaviors in adolescents or adults. For this reason, special consideration should be given children age 12 and under, so that their sexual behaviors are not necessarily labeled "deviant" or "offending" as would adolescents or adults engaging in similar behaviors.

Specifically, it is "developmentally expected" for children age 12 and under to engage in explorative, and impulsive sexual behaviors with youth similar in age. According to Johnson and Doonan (2006), healthy or "developmentally expected" sexual behavior by children is described as healthy sexual exploration as an information gathering process. These authors indicate that children may explore each other's bodies, look at and touch one another, or explore gender roles. It was noted that children involved in developmentally expected sexual behaviors are of a similar age, size, and developmental status. Also important, these children participate on a voluntary basis and the sexual behaviors are limited in type and frequency.

According to Johnson and Doonan, (2006), "If a child engages in sexual behavior due to curiosity, desire for knowledge, experimentation, anxiety, confusion, or if the child is replaying something he has seen or heard about or something that was done to him, and there is no element of anger, revenge, payback or desire for harm then the behavior generally should not be categorized as an offense." (p. 91). These authors further explain that children may act sexually due to their level of development wherein they use concrete thinking to problem solve or that they may play out their concerns or confusion. Essentially, children often learn experientially about sexual behavior.

The Continuum of Sexual Behaviors described by Johnson (2015) is a framework to identify the seriousness of sexual behavior in children ages 12 and under. She indicates that the vast majority of children's sexual behavior is natural and healthy. However, Johnson's model categorizes the problematic sexual behavior of children into three groups: 1) sexually reactive; 2) children who engage in extensive mutual sexual behaviors; and 3) children who molest other children.

Johnson (2015) reported that the first group is by far the largest of the three groups of children who engage in problematic sexual behaviors. These children typically engage in non-coercive sexual behaviors as an attempt to work through or understand their own sexual history in order to reduce anxiety. Children in the second group typically engage in a full spectrum of adult sexual behaviors on a more frequent basis and do so to relate to children. According to Johnson, these children usually have attachment issues due to abandonment. The children in the third group engage in frequent and pervasive sexual behaviors that may be aggressive in nature and may employ coercion, including manipulation. Johnson indicated that there are few children in this latter group, but when identified, they typically need specialized help.

Johnson and Doonan (2006) report that children, age 11 and under, who purposefully molest other children typically have common characteristics. These characteristics include intentionally touching sexual parts of another person, doing so across time and in different situations, displaying an unwillingness to stop when there is protest, having a motivation to act out negative emotions,

using force or types of intimidation to coerce others, and being unresponsive to consistent adult intervention.

Adolescent Sexual Behavior

Adolescence is a period of time with significant neurodevelopment as well as constant change in thought processes and understanding of the world. Therefore, it is critical to understand the difference between typical or expected adolescent behavior and that which is non-normative and unacceptable (Prentky, Righthand & Lamade, 2016). These authors further suggest that risk taking, sensation seeking, impulsivity, poor decision making, and like behaviors are not specific to delinquent youth, but common to most youth.

Longo and Prescott (2006) note that precise language is vital to understanding and treating youth who have sexually abused. Likewise, this same precise language must be used in assessing these youth. One must take into consideration the age, cognitive ability, and developmental stage of each youth assessed. Terms such as "sex offender" and "predator" are very problematic. These labels often cause harm to youth, if used loosely or inappropriately, as they can establish an inaccurate sense of identity (Longo and Prescott, 2006). It is an important distinction that a juvenile who has committed a "sexual offense" need not be labeled with the pejorative term, "juvenile sexual offender". It is therefore the position of NOJOS that the term "juvenile sexual offender" should be avoided. Additionally, terms such as "predator" should be used rarely and with caution. The use of terms such as "predatory behavior" is preferable to label acts, for example, that are perpetrated in a planned and purposeful manner with knowledge and acceptance of likely harm to victims. In general, it is simply preferable to label and define acts and patterns of behavior, not individuals.

"Sexual misconduct" is a term used in this assessment protocol to refer to hands-on and hands-off sexually behaviors that do NOT include force, coercion, malice, exploitation, or manipulation. This may include, for example, a 16-year-old who is criminally charged for having sexual intercourse with his 13-year-old girlfriend. Part of the reason this term was selected is in response to recent research and national concerns regarding the potential to stigmatize these youth and disrupt, rather than facilitate, their return to a normative path of development.

Careful attention to using this terminology for juveniles with sexual issues hopefully conveys NOJOS' belief and juvenile recidivism evidence that the majority of these youth will not go on to reoffend and that they can, through caring specialized assessment and treatment, return to a more healthy, normative path of development. Additionally, because extant literature also calls for juvenile intervention models to pair risk reduction with increased health and competency development, it is recommended that the assessor incorporate sex-specific assessment techniques into a more holistic, humanistic and developmentally consistent model for working with these youth. The risk-need-responsivity model, recommended by Prentky, Righthand and Lamade (2016) addresses all critical phases of completing a comprehensive assessment that addresses the needs of the youth as well as the risks and that the responsivity bridge the gap between needs and interventions.

Intent of sexual behavior must be taken into consideration in the evaluation process, as it places the youth's sexual behavior in perspective. Longo and Prescott (2006) note that not all youths who have been charged with sexual offenses have a true sexual disorder. There is a vast difference between a youth who is engaging in sexual misconduct in an opportunistic or exploratory manner versus one who engages in sexual offenses in a purposefully harmful or antisocial manner. Prentky, Righthand and Lamade (2016) point out that there is a great heterogeneity of youth who

are charged with sexual crimes, ranging from youth who are ignorant of the law to youth who are caught up in the sexual arousal of the moment to youth with sexual deviancy problems. Typically, the examiner would review the alleged reasoning behind the offense, the sexual arousal and/or sexual fantasy pattern, the number of and intensity of offenses, etc. These factors may help determine risk and level of treatment needed.

Low functioning youth and youth with mental illness (including Autism Spectrum Disorder) must receive special consideration during the evaluation process. The examiner must understand the dynamics of any specific disorder(s) attributed to the youth. Additionally, the examiner must understand how various disorders can affect risk factors, risk measures, polygraph examinations, and the way in which the individual relates to others and to his environment. These dynamics may preclude using specific measures or instruments as part of the assessment. Also, the evaluation should address specific needs of the youth based on any such disorder. Moreover, any neurodevelopmental deficits should influence the conceptualization of how the individual's sexual behavior is categorized and defined as discussed above.

Definitions of Sexual Assessments

A **Sexual Behavioral Assessment (SBA)** is completed on youth usually **under the age of 12** wherein sexual risk instruments cannot be applied directly due to the youth's age. This does not necessarily mean that no evaluation can be made about potential risk to the individual or community, but criminal prosecution is rarely (if ever) recommended for these youths. SBAs may also be completed on youths who have not committed "sexually assaultive behavior." For example, the youth may have engaged in sexual misconduct, but the behavior is considered somewhat developmentally expected (e.g. underage male youth engages in sex with another underage "girlfriend", "sexting", use of pornography, etc.).

If the youth has not committed a sexually assaultive offense or engaged in known deviant sexual or lewd behaviors, sexual risk factors cannot *easily* be evaluated or appropriately evaluated using risk instruments. Rather, a sexual "behavior" assessment is appropriate to examine this youth's overall sexual functioning and the nature of his/her sexual behaviors. This assessment focuses on the underlying motivations and the youth's needs that are not being met in an age appropriate manner. Environmental risk is addressed, recommending what environmental factors need to be put in place to minimize risk until the youth can eliminate the inappropriate sexual behaviors. These environmental factors include recommendations for specific supervision requirements, association, proximity and contact allowed or prohibited with younger children (or other vulnerable individuals identified by characteristics of potential victims based on the youth's victim selection characteristics, if any, etc.) and any known emotional or situational triggers identified in the assessment that need to be monitored. In other words, in these assessments, statements of risk are made about the environment(s) in which the individual finds themselves. The juvenile's potential risk to himself or others, as well as any pattern of risky behavior, is put in the context of these environments, circumstances, historical events, and developmental factors.

A **Sexual Behavioral Risk Assessment (SBRA)** reviews the youth's sexual behaviors and patterns. This assessment focuses on the underlying motivations for sexual misconduct and the youth's needs that are not being met. Environmental risk is addressed, recommending what environmental factors need to be put in place to minimize risk until the youth can stabilize the inappropriate sexual behaviors. Additionally, this assessment reviews the juvenile's sexual misconduct history, present functioning and treatability, and estimate of sexual re-offense risk. This assessment focuses on social and sexual history and provides an outline of risk factors along

with a recommendation of treatment level, supervision needed, and safety planning. Originally, the SBRA was used as an interim assessment to address placement needs while the psychosexual evaluation was being completed. Another appropriate use is if the youth has already had a recent psychological evaluation and now needs a sexual risk assessment due to sexual behaviors. One more use of the SBRA may include situations when there are no indications of mental illness, significant delinquency or substance abuse, or intellectual/learning disabilities. In these cases, the SBRA is considered appropriate practice.

A **Psychosexual Evaluation** assesses all personal, historical and environmental factors addressed by the SBRA. However, a psychosexual evaluation is also a comprehensive evaluation that contains psychological testing and psychological diagnosis in combination with an assessment of the juvenile's sexual behaviors and sexual risk. This is best practice, as it is a more thorough type of evaluation. Understanding psychological functioning is significant in determining risk factors as well as prognosis for treatment. A psychosexual evaluation gives a complete picture of the juvenile's mental health and general psychosocial functioning, as well as outlining risk factors and recommending an appropriate treatment level.

Qualifications of a Licensed Professional to Provide Assessment

At a minimum, to qualify as an adolescent sex-specific therapist or evaluator the clinician needs to have sex-specific experience, expertise, and training in the following specialized skills: (1) adolescent development involving expected and normative attitudes, emotions, experiences, interactions, and behaviors of childhood and adolescent development; (2) juvenile antisocial behavior or deviations in child and adolescent behavior that fall outside of age-appropriate and age-expected social norms that propel the youth to engage in antisocial or criminal behaviors in an effort to meet personal needs; (3) adolescent psychopathology involving the nature and diagnosis of mental disorders; (4) adolescent assessment requiring the capacity to evaluate, understand and interpret behavior with a special emphasis on projecting risk for future antisocial and sexually abusive behavior; (5) and knowledge of the dynamics of healthy sexual development and development of sexually abusive behavior including its onset, and maintenance over time. (Rich, 2009)

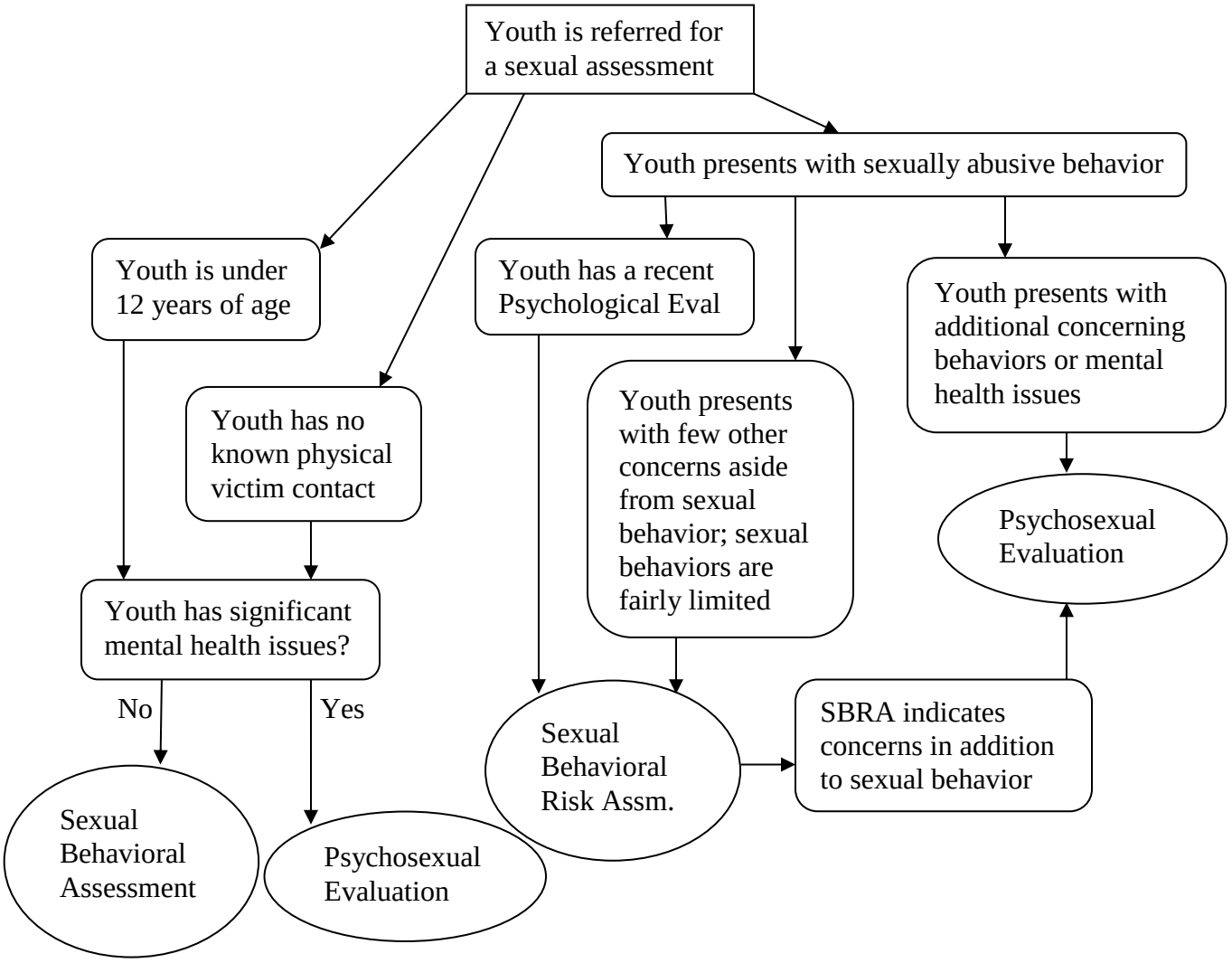
For a Psychosexual Evaluation, the psychological testing must be completed by a licensed psychologist or a psychologist resident/intern/student under proper supervision of a licensed psychologist, who has proper training in test administration (i.e. completed graduate or post-graduate courses in testing). The sexual assessment portion of the evaluation may be completed by a Master's level licensed mental health professional or a qualified Master's level intern/student under proper supervision.

The SBRA and/or SBA may be completed by a Master's level licensed mental health professional or a qualified Master's level intern/student under proper supervision.

It is strongly recommended that any practitioner in the State of Utah completing a Psychosexual Evaluation, SBRA and/or SBA be credentialed by or affiliated with *The Utah Network on Juveniles Offending Sexually (NOJOS)* or be supervised by a clinician who is credentialed. This would be considered best practice. This credentialing includes having supervised experience in sex-specific assessment and/or treatment, having annual training in sex-specific assessment and/or treatment, completing a background screening, signing a service provider agreement, and signing an ethics statement. Naturally, there would be serious concern regarding clinicians who practice

outside of their scope of expertise and conduct these types of assessments without proper training or supervision.

Guidelines of Which Evaluation Is Appropriate to the Situation



Procedures Necessary for Sex-Specific Assessments

1. Face-to-face interview with the juvenile in question.
2. Collateral interview(s) with parent, guardian, treatment provider etc.
3. Review of relevant documentation of the sexual act(s) in question (e.g. police report, victim statement, Children's Justice Center interview, Child Protective Service investigation report, etc.).
4. Use of objective risk tools (when appropriate).
5. Psychological testing (for psychosexual evaluations).

Components of a Sex-Specific Assessment

There are nine essential components of a **Sexual Behavioral Assessment (SBA)**. They are outlined as follows:

1. Social History of Juvenile:
    a. Family Dynamics/Functioning;
    b. Psychological Functioning/Past Treatment/Psychotropic Medication;
    c. Medical History/Early Development;
    d. Executive Functioning/Cognitive Ability/Emotional Functioning/Coping Skills;
    e. Social Functioning;
    f. School Functioning;
    g. Behavioral Functioning/Criminal History/Substance Use;
    h. Summary of Protective Factors (if not included in other areas).

2. Parent Input:
    a. Current Concerns for Juvenile;
    b. Juvenile's Social History;
    c. Understanding of Sexual Risks/Safety Plan/Environment;
    d. Risk to Other Children in the Home;
    e. Ability of Parent(s) to Provide Supervision and Facilitate Treatment.

3. Mental Status Examination

4. Sexual History:
    a. Sexual Victimization;
    b. Consensual Sexual Behaviors/Dating;
    c. Sexual Education;
    d. Pornography/Masturbation/Fantasy;
    e. Sexually Deviant Behaviors.

5. Description of Juvenile Sexual Behavior in Context of Age Appropriateness:
    a. Full Description of Each Sexualized Behavior/Sexual Offense (Invasiveness):
        i. Victim Profile/Age Difference/Relationship/Maturity-Cognitive Ability;
        ii. Context of Sexual Behavior and Other Person Involved;
        iii. Number of Incidents/Timeline/Environment;
        iv. Criminal Charges Adjudicated/Pending.
    b. Use of Coercion or Force/Reaction to Victim Protest/Attempts at Secrecy;
    c. Accountability/Empathy/Remorse;
    d. Current Level of Safety/Environmental Factors/Risk to Children in the Home;
    e. Ability and/or Willingness of Parents to Supervise in the Home;
    f. Protective Factors;
    g. Past or Current Sex-Specific Treatment and Outcome.

6. Collateral Information Specifically Describing Sexual Offense(s)/Sexual Misconduct:
    a. Police Report (preferable);
    b. Children's Justice Center Interview;
    c. Victim Statement;
    d. Parent Report;
    e. Juvenile Sexual Offender's Response to the Collateral Information;

7. Impact for Victims in the Home;

8. Recommended Treatment Level Using NOJOS Standards (Levels One through Eight)

9. Recommendations in General (include any of the following as well as other concerns):
    a. Protective Factors;
    b. Placement Appropriateness;
    c. Need for Family Intervention;
    d. Safety Plan/Supervision Needs;
    e. Reunification Needs;
    f. Recommendation for a Polygraph Examination (if age appropriate);
    g. Assessment of other potential victims; issues of possible non-identified victims;
    h. Treatment for Compulsive/Excessive Pornography and/or Masturbation;;
    i. Mental Health Issues;
    j. Need for Psychiatric Services/Medication Management;
    k. Alcohol or Drug Treatment;
    l. School Issues/Education Deficits;
    m. Social Issues;
    n. Recommendation for Further Assessment (Psychological, Neuropsychological);
    o. Criminal Background Check of Approved Supervisor(s);
    p. Treatment Provider Training of Approved Supervisor(s);
    q. Etc.

There are three additional essential components of a **Sexual Behavioral Risk Assessment (SBRA)**, which include:

1. Risk Instruments for Consideration:
    a. JSORRAT-II;
    b. JSOAP-II;
    c. ERASOR-II.

2. Other Instruments To Be Considered:
    a. Protective Factors Survey;
    b. MSI-J;
    c. Screening Measures for Non-Sexual Issues;
    d. Behavioral Rating Checklists (e.g. BASC-2, Auchenbach, CBRS).

3. Statement of Risk, Including Mitigating Factors (Who, What, Where, When).

There are three additional essential components of a **Psychosexual Evaluation**, which include:

1. Psychological Testing Instruments To Be Considered For Use:
    a. Cognitive Assessment:
        i. e.g. WISC-IV, WAIS-IV, WASI-II, Stanford Binet-5, Woodcock-Johnson Cognitive-III, Shipley Institute of Living Scale-2; Slossen Intelligence Test Revised, 3rd Edition;
        ii. Adaptive Functioning Assessment (e.g. Vineland-II).

b. Psychological Testing (at a minimum one personality measure should be included; additional testing is based on the referral question and basic screening is recommended for suicidal ideation; clinical judgment determines the battery):
   i. Personality Testing (e.g. MMPI-A, Jesness Inventory, MACI);
   ii. Behavioral Checklists (e.g. Achenbach, BASC, Conners CBRS);
   iii. Symptom Checklists (e.g. YOQ-Self-Report/Parent Report);
   iv. Depression/Anxiety Screening (e.g. Beck, CDI, MASC);
   v. Suicidal Ideation Screening (e.g. SPS, Beck, RFL-A);
   vi. Drug and Alcohol Screening (e.g. SASSI-A2);
   vii. Autism Spectrum Disorder Screening (e.g. SCQ, ADOS);
c. Educational Testing/Screening (dependent on the referral question):
   i. Full Battery (e.g. Woodcock-Johnson III, WIAT-III);
   ii. Screening (e.g. Wechsler Fundamentals, WRAT-4);
d. Other Testing as Needed (e.g. neuropsychological, autism, sensory).

2. Full DSM-IV/5 Diagnosis (Five Axis)/ICD-10 Codes.

3. Statement of Prognosis.

Recommendations Guideline

Recommendations should always focus on what is needed by the youth, and should not necessarily be limited to what is available in that particular community. Although certain programming, NOJOS levels, or other treatment modalities may not be readily accessible in certain situations, the clinician should make recommendations specific to what is in the best interest of the youth.

It is strongly recommended that treatment recommendations comport with the current NOJOS Treatment/Placement Protocols and Standards and time frame guidelines outlined therein. The time frames may vary depending on individual needs of the youth, but should be consistent with the NOJOS standards outlined.

Additionally, it is recommended that an updated sex-specific assessment occur prior to any change in treatment, such as discharge or a step-up/step-down within the NOJOS continuum. This may occur as a separate assessment, such as a Post-Treatment Assessment, or as part of the Discharge Summary.

Special Issues

Overriding Principle Regarding Placement/Treatment Decisions with Juvenile Sexual Offenders

Consistent with the original Utah legislative mandate (Utah State Code 78A-6-102 Annotated Establishment of juvenile court -- Organization and status of court – Purpose) which established the juvenile court, those evaluating juvenile sexual offenders for the purpose of making recommendations regarding treatment/placement should, whenever feasible, attempt to find ways to keep the juvenile sexual offender in their home with their family of origin. If the continued risk to the public safety cannot be mitigated by means of outpatient treatment and /or education, line-of-sight supervision, alarms, etc., then those evaluating and making treatment/placement recommendations should adhere to the concept of 'least restrictive alternative environment' and consider kinship placement (relatives, family friends, etc.) in lieu of placement in group homes, residential treatment centers, etc. The desires of the parents or guardians of juveniles should be

considered when making recommendations regarding treatment/placement. It is important to note that juveniles who have committed a significant sexual offense against a family member in the family home should, under the vast majority of circumstances, be removed from that home for a period of time. That period of time can vary greatly depending on the circumstances of the perpetrator, victim, and family. The reasons for this removal go far beyond simply preventing a reoccurrence of the offense, which is why increased supervision is inadequate to address the needs of the victim and perpetrator.

Caution Regarding Sexual Risk Instruments

Objective sexual risk instruments are limited in their scope of use, such as being specific to age and gender. At this time there are no known sexual risk instruments to use for female juveniles who have committed a sexual offense. Likewise, risk assessment instruments may not be appropriate for youths of a certain developmental status, such as developmental delay or mental retardation. It may also be inappropriate to apply risk instruments to youth on the autism spectrum because their unique problem set likely falls outside the class of adolescents considered in research for these instruments and thus are not likely representative of these youth. Caution must be used with these instruments, as they are not "stand-alone" measures, as noted earlier. Naturally, the clinician must be responsible to use the appropriate sexual risk instruments and other assessment tools for each individual case.

Caveat of Communicating Risk

There is a dearth of research that addresses cut-off scores for risk labels, and thus it is difficult to apply a risk category to a youth by using supporting data. The preponderance of data should support any label or given risk category. In other words, caution should be exercised when assigning labels such as "moderate risk or high risk". More specifically, what constitutes "moderate risk" is very poorly defined, somewhat arbitrary, and varies greatly from clinician to clinician. It is imperative that the assessor understand the temporal stability of the youth at the time of assessment, and how sexual risk is ever-changing. Because of this, it is recommended that risk assessment is visited every few months, and that any risk category or label used is not considered relevant as time lapses. (Prentky, Righthand & Lamade, 2016).

Use of the Polygraph Examination

In most sex-specific assessment cases (specifically adjudicated cases), the polygraph examination is highly recommended. This is a means to assist in the treatment planning process, as it facilitates a more clear understanding of the juvenile's offense history and/or sexual misconduct and scope of offenses. Perhaps more importantly, the polygraph is invaluable in determining if the juvenile has offended against other previously unknown victims. A polygraph is oftentimes the means by which these unknown victims can receive needed attention and treatment. For example, if it is not known that the juvenile has offended against a family member in the home, then it may not be possible to make proper recommendations about treatment and placement. It is beneficial for the polygraph examination to be given in conjunction with the sexual assessment, thus allowing the sexual assessment to address the fully disclosed sexual behaviors. Often, a polygraph examination as part of the assessment process can quicken the progress of treatment, as well as to identify the victims whom should be addressed in the treatment process. Regarding the sexual assessment, it is important to make clear the sources of disclosure (e.g. if the disclosure was made via the polygraph examination versus volunteered by the youth in the assessment interview).

As indicated, polygraph examinations are an extremely helpful and often a necessary tool in conducting a sexual assessment. However, these examinations are used as part of the assessment or for treatment, and they are not intended to be used a means to seek further adjudications. Nevertheless, any new victims disclosed in the polygraph examination should receive the same considerations as victims initially disclosed or reported, as they will also have needs to be met, such as a need for treatment, apology, and/or reunification. One must keep in mind that the majority of additional offenses disclosed in a polygraph examination do not need to be adjudicated, but this is at the discretion of the judicial system.

It is understood that certain populations, including low functioning youth, developmentally delayed youth, youth with Autism Spectrum Disorder, or youth under age 12, are not appropriate for a polygraph examination.

For further information regarding appropriate candidates for the polygraph examination, please refer to the American Polygraph Association's 2012 *Model Policy for the Evaluation of Examinee Suitability for Polygraph Testing*.

Additional Offenses Disclosed During Assessment/Treatment Process:

During the course of assessment and/or treatment, new victims may be disclosed by the youth. It is important to consider if the perpetration occurred prior to or subsequent to the presenting offense which initiated the assessment or assignment to treatment. There are mandatory reporting laws for consideration of the newly disclosed victims' needs, regardless of the timeline of the perpetration. However, it is frequently not in the best interest of the youth who offended to be adjudicated for newly disclosed perpetrations committed prior to the presenting offense, assessment, or treatment. On the other hand, it is likely imperative that any perpetrations subsequent to assessment and/or treatment be prosecuted.

Level One:
In-Home / Outpatient Psychosexual Education

Client Profile:

Youth appropriate for a Level One intervention are typically in one of two categories:
1) Younger children and adolescents with no previous known history of sexual acting out, or who have engaged in sexual misconduct on one occasion, or who have displayed low-frequency sexual behaviors. Sexual incidents are isolated, exploratory and/or situational in nature with no use of coercion or violence, and there is no evidence of progression of offense behavior; or
2) Adolescents who, in the course of a normative* consensual, "non-coercive" relationship, administer sexual touches or receive or perform sexual behaviors. However, based on the age or development of one of the parties, these behaviors are illegal (i.e. sixteen-year-old with a fourteen-year-old). Specifically, one party may not legally consent based on the legal definition of the age of consent. The problem must strictly lie in the issues of consent, not in equality, coercion or level of understanding.

Both categories of youth have typically had little exposure to healthy sexual information and experiences, present with low culpability and their sexual behavior tends to be less intrusive. They have little insight in the wrongness or consequences of their behavior. These youth may be impulsive. They may have gained sexual information beyond their developmental readiness. Their sexual misconduct is usually as a result of deficits in their fund of sexual knowledge and understanding of consequences rather than distortions in their cognition or deviancy. These youth are a ***low risk*** to the community, as assessed by nationally-recognized risk-assessment tools, and the majority of them have a good parental support system that is fairly functional. These youth may or may not be adjudicated; however, adjudication may be helpful and is recommended to ensure compliance.

> * Moral, social, and/or familial rules may restrict, but these behaviors are not *abnormal*, developmentally-harmful and/or illegal when private, consensual, equal and non-coercive. Stable monogamy is defined as a single sexual partner throughout adolescence. Serial monogamy indicates long-term (several months or years) involvement with a single sexual partner that may be preceded or followed by similar long term monogamous relationships (Ryan, G. and Lane, S. Editors; Juvenile Sexual Offending; Causes, Consequences, and Correction, Jossey-Bass Press, 1997).

Treatment Goals:

Level One programs include public and private community-based mental health programs that provide a short-term, age-appropriate collateral psycho-educational module on human sexuality and healthy human sexual behavior, including detailed material on sexual misconduct and child

sexual abuse definitions, consequences and strategies for identifying, avoiding and coping with the contributing factors and risky sexual behavior situations (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 51).

The primary goals of Level One treatment are to:

1. Educate the youth to ensure that he or she understands what is appropriate versus inappropriate and legal/illegal sexual behavior;
2. Develop and/or augment a healthy fund of sexual knowledge;
3. Enhance his or her responsible adaptive level of functioning socially, emotionally and sexually; and
4. Place youth on (or back on) normal developmental trajectory of sexual development.

Treatment Modalities and Frequency:

The primary treatment modalities are short-term individual or group therapy. The youth's family should be included in the treatment. Treatment is weekly and short-term (approximately two to three months based on curriculum and the youth's need). Treatment **is not** traditional individual therapy and should be provided in an educational manner (although treatment may occur in an individual session). A structured 8-12 week curriculum with stated objectives, assignments, and goals is recommended. Treatment includes homework (individual and family assignments), psycho-educational assignments as well as parent involvement. Treatment interventions can include experiential exercises, sensory interventions, observation in the community, parent education, development of social skills and ongoing assessment of risk. If there has been a "hands on" victim, additional victim empathy work may be necessary. This would typically be 3-9 individual sessions if programming is provided in a group setting and an additional 3-9 sessions if provided in an individual setting.

Targeted sex-specific treatment is contra-indicated for Level One youth. Every effort should be made to avoid the "contagion effect" for these youth by ensuring that youth placed in a psychosexual educational group are similar in age, development and social ability, as well as sexual risk. For example, it would be inappropriate for a Level One youth to participate in a Level Two Sex-Specific Group (where detailed information about sexual-offense behavior is discussed) and/or be introduced to targeted sex-specific curriculum.

Treatment is more about aiding youth to understand their sexuality and sexual development, owning responsibility for their sexuality (thoughts, feelings and behavior), identifying that there are consequences for their choices and entering or re-entering a normative developmental pathway for their sexuality.

Treatment Focus:

Group or individual therapy should follow a structured curriculum, ideally 8-12 weeks in duration, with the inclusion of the youth's parent(s) in the process. There should a systematic manner to measure the attainment of the psycho-sexual education provided. The treatment should incorporate, enhance, and provide psycho-education for the following:

- Sex education (including maturation, sexual anatomy, sexual physiological responses, etc.);
- Sexuality education—recognition they are a sexual being and sexuality is a part of their life and current stage of development; that sex has meaning and purpose in life, and an understanding of what meaning sex plays in their life; and developing the competency to establish healthy sexual relationships (as defined by personal values); how to communicate effectively regarding sex and sexuality;
- The distinction between healthy versus unhealthy sexual functioning and behavior; Developmentally-expected child/adolescent sexual behaviors and sexual development;
- Current abuse laws and consequences governing sexual behavior;
- Accountability;
- Values clarification and healthy sexual attitudes;
- Self-esteem and healthy identify development, including positive body image;
- Teaching emotional and self-regulation skills;
- Identification and healthy expression of feelings;
- Anger management skills;
- Stress management and emotional-coping skills;
- Increased understanding of interpersonal boundaries;
- Empathy development;
- Interpersonal relationship skills and assertiveness; and.
- For those with hands-on victims, clarification work should be included.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions must be certified by NOJOS as a sex-specific provider with training in adolescent development, trauma and neurophysiology, as well as etiological and maintenance factors that impact developmental trajectory. However, if the psychosexual education is not provided by a licensed mental-health clinician, the individual must be trained and competent to provide the service and be supervised by a NOJOS certified sex-specific clinician.

Monitoring:

NOJOS certified sex-specific clinicians and youth's parents/guardians monitor non-adjudicated youth while the Juvenile Court monitors adjudicated youth. Cases involving sibling incest may benefit from protective supervision by the Division of Child and Family Services (DCFS). Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS certified sex-specific clinician(s). All chaperones/approved supervisors must be educated of the youth's risk factors in order to provide appropriate supervision.

Criteria for Discharge:

Criteria for treatment progress include, "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, page 52). More specifically, each client should demonstrate increased

understanding and fund of sexual knowledge regarding their sexuality and sexual development, responsibility for their sexuality (thoughts, feelings, and behavior), understanding of the consequences for their choices and evidence of entering or reentering a more normative developmental pathway for their sexuality and adolescent development and be able to demonstrate this increase through a consistently applied tool (i.e. a quiz regarding the content taught) as well as general observation. Additional recommendations based on observations may be made, but youth completing the requirements for discharge should "successfully complete" the assigned course.

Level Two:
In-Home / Outpatient Sex-Specific Psychotherapy

Client Profile:

Level Two youth not only need psychosexual information (as outlined in Level One), but they also present with a need for directed sex-specific clinical intervention. Typically, these youth are first-time offenders, or they may have successfully graduated from a higher level of care and need ongoing outpatient services for step-down transitional and aftercare purposes. These youth may present with a slightly greater frequency and duration of sexual misconduct than a Level One youth. They may have one or more victims, but typically do not have indiscriminate choice of victims (i.e., male and female victims, related/unrelated victims and/or toddler and peer victims). Their sexual behavior may have been more intrusive, but displays minimal evidence of progression from less-intrusive to more-intrusive sexual behaviors. Additionally, these youth typically meet one or all of the following: 1. lack of consent, which means one of the parties does not a) understand what is proposed without confusion or trickery; b) know the standard for sexual behavior in the culture, the family and the peer group; c) posses awareness of possible consequences including stigma, punishment, pain and disease; and d) have respect for the agreement or disagreement without repercussions; and/or 2. a lack of equity between parties, meaning there is a inequality in the authority, power and control within the relationship; and/or 3. the presence of coercion, meaning pressure to comply (either explicit or implied) has been exerted in order to get someone else to do something (Bonta and Andrews, 2016).

Overall, these youth are disclosing and acknowledge some accountability for their sexual misconduct. They generally display feelings of guilt or shame, although they do not always demonstrate empathy, either due to their developmental stage or lack of understanding of the impact on others, or they have barriers that have prevented the development of empathy. These youth typically present with adequate community support, are willing and able to comply with safety restrictions and are amenable to treatment. In limited circumstances, these youth may present with moderate risk; however, the youth's family or caregivers are able and willing to provide appropriate supervision and comply with treatment recommendations, and it is determined that this supervision provides an accepted protective factor to ameliorate risk of re-offense. These youth typically do not present with a strong patterns of oppositional behavior or conduct disorder; however, they may present with other diagnoses including clinically-significant depressive symptoms, anxiety and/or impulsivity/attention problems. The majority of Level Two youth are ***low and/or low-to-moderate risk*** as assessed by nationally recognized risk assessment tools.

Adjudication is strongly recommended. Few providers, if any, will treat this population on an outpatient basis without court involvement.

The significant difference between Level Two and Level Three and Level Four youth lies in the protective factors, resiliency and internal and external assets of the youth. Level Two youth present with more protective factors internally, as well as in their environmental and family functioning and school functioning—they also have higher levels of resiliency and internal assets that act to lower or offset their risk to offend. Further, Level Two youth, based on clinical assessment, are able to be managed safely in their home environment and traditional school setting.

Treatment Goals:

Level Two programs should provide individual, group and family therapy, as needed, offering traditional adjunct mental-health services (with variations in focus, model, and duration) and sex-specific services. These programs should provide abuse-specific interventions, cognitive-behavioral content, risk management, and strength-based skill building. Sex-specific treatment also often includes modules based on healthy living and decision-making, increasing self-monitoring of behavior, understanding thoughts, feelings, behaviors and consequences associated with sexual misconduct, and strategies for managing inappropriate sexual behavior, etc. (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52).

Identified sex-specific treatment issues or goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home settings.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented on pages 14-15.

Treatment Modalities and Frequency:

Based on the youth's presenting problems and needs assessment, Level Two treatment can vary in focus, intensity, duration and frequency. This typically can be expected to last 6-10 months, but may take longer based on individual issues and/or needs. Nevertheless, Level Two treatment must include targeted sex-specific therapy and psychosexual education, as well as adjunct with traditional mental-health therapy. However, in some circumstances some youth may only need traditional non-sex-specific therapy with adjunct Level One Psychosexual Education. Further, in rare circumstances where the youth presents as vulnerable and naïve (i.e. low ego strength, extremely immature, etc.), group intervention may not be beneficial and/or appropriate.

The primary Level Two treatment modalities include individual/family, group and parent-group sessions. At a minimum, individual and targeted sex-specific group sessions should occur weekly. In some circumstances, based on the youth's needs, it may be necessary for a youth to participate in more intensive sex-specific outpatient services to include two to three sex-specific sessions per week. Parent* groups and family therapy should occur at least bimonthly. Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety and assisting the youth to manage his/her risk. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. It is important to view the parent/guardian as part of the treatment team and empower them to be an active participant in the youth's treatment. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues. Additionally, Level Two youth may require psychiatric/medication management services, skills development services and/or psychological services.

*Given that some youth may not have parents, when the term "parent" is used, it includes the youth's parents, caregiver, and/or primary-support system.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

Monitoring:

Ideally, all Level Two youth should be referred to the Juvenile Court for delinquency (not just dependency). Court involvement provides additional supervision for community protection and sanction supporting youth accountability. The juvenile justice authority and/or DCFS/DJJS treatment team, in conjunction with the NOJOS certified sex-specific clinician(s), act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. Chaperones for youth who have engaged in sexual misconduct need to be approved by the NOJOS certified sex-specific clinician(s). All chaperones must be educated about the youth's risk factors in order to provide appropriate supervision. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. Guidelines should include those adults who have been approved to supervise the youth, contact restrictions (if any), restrictions around bathroom use, hygiene practices (bathing, dressing, etc.), nighttime routines, caretaking responsibilities and involvement in, and supervision of, extracurricular activities.

Criteria for Discharge:

The NOJOS certified sex-specific clinician(s) and the treatment monitoring team evaluate the youth's treatment progress. Criteria for treatment progress include accomplishing the treatment goals and objectives, self-responsibility, changes in thinking, and observable implementation of skills. The youth should also demonstrate increased competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages); the ability to obtain their needs and human goods in a healthy way; and to place themselves back on a healthy pathway towards becoming a functional, healthy, happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

The National Task Force on Juvenile Sexual Offending also identified specific treatment progress indicators in their revised report (1993). Adaptations of these guidelines include:

1. Understand, identify, and interrupt thoughts, feelings, beliefs, and behaviors that contribute to abuse and all unhealthy choices and behaviors;
2. Develop responsibility for personal choices and behavior without minimization or justification;
3. Understand the impact of past trauma on self-image, functioning, difficulties, and behaviors;
4. Develop awareness, sensitivity, and compassion for others;
5. Learn and understand how to differentiate normative and unhealthy sexual development;
6. Identify, interrupt and control, unhealthy and/ or inappropriate sexual arousal, thoughts, and fantasies;
7. Learn and use adaptive coping and social skills;
8. Build and engage in non-coercive, reciprocal relationships; and
9. Develop and demonstrate effective use of self-management strategies and a relapse prevention plan.

The client's self-regulation/healthy living plan must include identification of personal risk factors and knowledge of community resources in case of a relapse. Youth who are uncooperative with treatment, deny or minimize sexually-abusive behaviors, resist treatment intervention, are unable or are unwilling to comply with treatment recommendations and/or identify and manage risks, or continue to exhibit sexually inappropriate behavior, will require additional intervention. It may be also be appropriate to refer such youth to a more intensive/restrictive level of treatment and supervision. However, while all the above potentially indicate that the youth's risk has increased, a reassessment of the youth's risk and current Level of treatment should be conducted. Further, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than solely on resistance and/or noncompliance.

It is recommended that Level Two youth undergo a discharge assessment to determine if:

1. Co-morbid issues have been addressed/stabilized;
2. Risk has been lowered;
3. Level of functioning/skills have improved;
4. A stable support system has been developed;
5. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
6. Protective factors, resiliency, internal and external assets have been increased; and
7. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

Level Three:
Sex-Specific Day Treatment/Intensive Family Based Services

Client Profile:

Those youth appropriate for Level Three intervention differ from Level Two youth in that they present deficits in executive functioning, and/or have significant peer or family-based risk factors. They also require more management in their school and/or home environment.

Level three youth may fall into one of two categories:

1. Youth with significant family-based issues who require Intensive Family Based Services (IFBS). This program provides in-home family counseling and behavioral intervention services in addition to sex-specific individual, family, and group counseling. This program targets unhealthy or risky home environments, both sexual and non-sexual delinquency problems, families with a history of abuse and neglect, attachment problems, and parental mental health issues. Youth in need of level three in-home services have significant family risk factors, but also have good support from extended family and other strengths that may be mobilized through the intervention program. These youth need services that are intensive and family based to address sexually abusive behaviors, general criminal behaviors, as well as the family environment that contributes to ongoing risk. Youth with significant risk factors related to the family and parents are good candidates for Intensive Family Based Services. The family based services provide an important step-down service for youth transitioning from a higher level of care and returning home.

2. Youth with significant deficits in executive functioning who require the structure of an Intensive Day Treatment Program.

Many youth in both treatment categories have preexisting co-morbid mental health issues and may have been in treatment prior to engaging in sexual misconduct.

Treatment Modalities and Frequency:

Intensive Family-Based Services

Family based services provide intensive, sort term services that target specific risk factors identified in the initial risk assessment, commonly targeted factors known to contribute to sexual and criminal recidivism (see Risk-Need-Responsivity Model; Andrews & Bonta, 2003), as well as skills "to live fulfilling and personally satisfying lives" (see Good Lives Model and RNR; Ward and Yeates, 2007, p. 223). Family factors commonly targeted include: parenting skills, appropriate discipline, criminal and exploitive attitudes, family structure, roles in the family, healthy boundaries, healthy sexual education, productive family communication patterns, problem solving skills, conflict resolution.

Intensive family based services typically provide between 4-12 hours of clinical and behavioral intervention services per week, dependent on family need and level of risk. Minimum services per week should include:

1. One hour individual therapy session with the youth.
2. 1-2 hours of two family therapy in-home.
3. One sex-specific group therapy session per week.
4. Parenting skills coaching for parents and/or support group for parents are highly recommended to provide positive parenting techniques and mutual support for parents dealing with the complex dynamics of sexual abuse in families.
5. More frequent individual or family therapy may be indicted according to need.
6. In-home skill building for parents and the youth focused on developing behavioral competency and parenting strategies in areas surrounding risk reduction factors identified through the risk assessment and clinical interventions.
7. Safety plan adherence through frequent (3-4 per week) in-home observations by behavioral specialist.

In-home family therapy and behavioral intervention sessions are targeted at risk factors, skill-intensive, directive, and short-term. The treatment process falls into three phases:

1. Focus initially is on family engagement, development of multi-disciplinary support team, assessment of family strengths and needs, the reduction of risk in the home, and implementation of safety plans.
2. Phase two addresses family structure, consistency, roles of family members, discipline practices, conflict resolution, problem solving, and communication.
3. Phase three focuses on practice of new skills, relapse prevention, healthy sexual boundaries in the family, aftercare planning, identification of support systems, termination or transition to less intensive treatment program.

Specific evidenced based models may be used or incorporated to guide interventions e.g. Multi-systemic Therapy (Henggler), Functional Family Therapy (Alexander), Family Strengthening Program (Kumpfer), and the Teaching-Family Model (Families First).

The length of Intensive family-based services depends on the risk level and needs of the youth, as well as the needs of the family. The intensive in-home services should last from 60-90 days. Many times the youth may be transitioned to a NOJOS Level II program for ongoing treatment until discharge.

Level Three Intensive Family-Based Services (IFBS)

Intensive Family Based Services core principles:

1. The most effective treatment for sexual misconduct targets not just the intrapersonal risk factors associated with the youth, but the risks present in their immediate social environment (Walker et.al. 2008; McCann & Lussier, 2008).
2. The removal of a developing adolescent from their family (or extended family) should only be considered after exhausting all the treatment options that could safely maintain the youth in the home environment.

3. An intensive family-based treatment program will allow higher-risk youth and families to receive treatment in community, reduce recidivism, and prevent more expensive out-of-home placements.
4. Youth with sexually abusive behaviors are at a higher risk to recidivate non-sexually than sexually, and treatment should target both sexual and non-sexual misconduct in treatment (CSOM 2006).
5. Most youth in the low to moderate risk category, and even some in the moderate to high risk category, can be effectively treated with short-term, intensive, in-home services.
6. Most youth with sexually abusive behavior problems eventually return home and are reunified with their families (and often their victims).
7. Interventions for sexually abusive youth must be research based and theoretically grounded. In the field of specialized treatment for sexually abusive youth the only treatment that has been systematically evaluated and proven effective through randomized clinical trials is Multi-Systemic Therapy (MST; Henggler, 2004; Letourneau 2008), an intensive family-based program.
8. Working effectively in a youth's natural environment necessitates inclusion of: parents, extended family members, mentors, therapists, probation officers, case managers, medical practitioners, teachers, religious leaders, and other natural support systems. The team approach to treatment and supervision improves outcomes and reduces recidivism.

Level Three Intensive Day Treatment Program

An intensive day treatment program will provide the elements of the intensive family-based program including working with the family. Additionally, this program will provide the youth with skills to improve executive functioning.

Level Four:
Sex-Specific Proctor or Foster Home /
Outpatient Sex-Specific Psychotherapy

Client Profile:

Youth appropriate for Level Four Proctor/Foster Care present with: (1) a risk that cannot be controlled in their current living environment; and/or (2) parents and caregivers who cannot provide adequate supervision; and/or (3) parents/caregivers who do not provide an adequate, healthy or safe living environment for the youth. The youth's environmental risks may include immediate or near-immediate access to victim(s) or potential victim(s), thus, rendering it as inappropriate. Further, the youth may not be able to continue residing at home because the sibling victim(s), and/or other victim(s) also residing in the home, need separation from the sexually-abusive youth to begin their healing process. A youth's removal from home is also necessary at times when the parent/guardian's denial/minimization of current risk is present, or they do not adequately understand or respect current risk of the youth such that it impacts their ability/willingness to provide adequate supervision. The youth may also present with deficits in executive functioning resulting in their inability to self-regulate sexual and/or nonsexual acting-out behaviors, and/or need behavioral modification or skill enhancement interventions that cannot be provided in their home environment (i.e. milieu clinical intervention).

Youth transitioning down from a higher level of care are also appropriate for a Level Four placement as a step-down option. In this situation, this level of care provides a less-restrictive environment for transition and practice of skills learned in more-intensive residential and/or secure care settings. Level Four also includes youth who are failing, or who have failed, at a lower level of placement on the NOJOS Continuum of Care (i.e., Levels One, Two and Three). However, to qualify for a Level Four placement, the failure is typically a result of environmental or familial issues rather than related to the youth's conduct or increase in risk. Furthermore, it is recommended that youth who fail at a Level Two intervention because of their conduct, resulting in an increase in their risk, be placed in either a Level Five or Level Six setting. Placement should then be considered based on current risk, behaviors, and treatment needs being able to be met and risk managed.

Level Four youth should be charged and adjudicated for their sexual delinquency in the Juvenile Court. The majority of Level Four youth are Court ordered into State's custody under the supervision of DCFS or DJJS who will provide, or who will contract with providers, sex-specific placement and treatment services. DCFS typically utilizes foster-home placements, and DJJS utilizes proctor-home placements.

Level Four Proctor/Foster Care is typically the first out-of-home alternative available on the NOJOS Continuum of Care. Specifically, Level Four youth require more-intensive structure and supervision than what is available in their current home environment—and/or the youth is in need of a transitional placement to practice, generalize and apply the skills learned in a more-structured environment. Level Four youth typically present as a ***moderate risk*** to the community as assessed by nationally recognized risk assessment tools. Level four youth are in

need of a placement based on issues within their environment, and thus, appropriateness for placement in Level 4 is based on the following criteria:

1. Deficits or issues within the home environment:
   a. Is marked by extreme stress or instability, and it is determined that this stress and instability will not provide the support or supervision the youth needs to address his or her treatment and/or supervision needs;
   a. The adults are incapable of, or choose not to, provide the level of structure and supervision required to prevent re-offense or assist the youth to deal with his/her treatment needs;
   b. The family, through their own behaviors, values and issues, does not provide a healthy environment for youth to heal;
   c. The family presents as enabling and/or denial-based;
   d. The family does not possess the skills or resources necessary to address the youth's clinical needs (i.e. skills enhancement, behavioral modification, regulation of co-morbid mental health issues, regulation of impulsivity, emotions, and behaviors).

2. Additionally, those youth who have successfully completed a higher level of care, such as a Level Six or Level Eight, may transition (step-down) to a Proctor/Foster Care setting, where they receive structure and supervision and are able to continue aftercare outpatient sex-specific treatment.

Level Four Proctor/Foster Care homes cater to the youth's sexual risk to ensure that the youth is placed with others similar in age and maturity and is not placed with children similar in age to the youth's victim(s), and/or potential/possible victims and/or older offending youth (which could subject the youth to contagion and/or risk of being victimized).

Level Four Proctor/Foster homes should AT MOST have one or two additional proctor/foster siblings in the same household. If the youth presents a risk to those younger than himself/herself, he or she should not be placed in a foster/proctor home with younger children or peers. If the youth presents a risk to same-age peers and younger children, the youth must be placed in a foster/proctor home with no other children. The youth's risk must be assessed prior to placement to avoid inappropriate placement—especially when there is a potential risk of reoffending.

Treatment Goals:

Level Four youth must participate in, and successfully complete, adjunct Level Two and/or Level Three sex-specific treatment as specified in these Protocols and Standards under those levels. There should be a specific focus on engaging the parent(s) and family unit in family therapy to address those family/parent based issues requiring an out-of-home placement. Specific care should be taken to ensure any victim contact as part of this therapy follow the NOJOS Resolution Continuum and this be coordinated with the victims therapist based on their individual readiness.

As mentioned previously, the National Task Force on Juvenile Sexual Offending (1993) has identified certain definable sex-specific treatment issues or goals. These goals include increases

in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment and stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented on pages 14-15.

Treatment Modalities and Frequency:

Level Four youth participate in Level Two and/or Level Three treatment provided by a contracted NOJOS certified sex-specific clinician (see pages 20- 21 above for Level Two and pages 25-26 for Level Three treatment modalities and frequency). Depending on current risk level, as well as the youth's presenting problems and needs, Level Four youth may attend school in a self-contained classroom such as Youth In Custody (YIC), Behavior Disordered (BD) classrooms or Level Three Sex-Specific Day Treatment educational programming. The NOJOS School Placement Protocol (see addendum to manual) should be consulted in these situations. When these youth attend mainstream school, a risk assessment **MUST** be completed and indicates that the youth's risk is at an acceptable level and/or can be safely managed in a traditional mainstream school setting.

Additionally, Level Four youth may require psychiatric/medication management services, skills-development services and/or psychological services.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment, social and culture on the youth.

Those individuals providing skills-development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS certified sex-specific clinician.

Individuals providing foster or proctor care for youth with sexual-behavioral problems must complete all pre-service training as required by the State Licensure and Department of Human Services requirements. They must also complete all other annual training as required by the state.

In addition, these parents must complete a minimum of twelve hours of training annually specifically focused on understanding and working with youth with sexual issues and sexual-behavioral problems. This training must include information regarding appropriate supervision techniques to be utilized with sexually-traumatized youth, hyper-sexualized youth and youth who engage in sexual misconduct. These individuals must also attend and complete the NOJOS Basic Line Staff Training. Individuals providing foster or proctor care must also be supervised by a Certified NOJOS sex-specific clinician. Foster and proctor parents should be active participants in treatment-team meetings, and where applicable, should attend monthly Division team meetings.

Trackers of youth with sexual issues should meet all state licensing and training requirements. They must complete twelve hours of training annually specifically focused on understanding and working with youth with sexual-behavioral problems. This training must include information regarding appropriate supervision techniques to be utilized with sexualized youth and youth who engage in sexual misconduct. These individuals must also attend and complete the NOJOS Basic Line Staff Training and be supervised by a NOJOS certified sex-specific clinician. It is also recommended that trackers are active participants in treatment-team meetings, and where applicable, should attend monthly Division team meetings.

Monitoring:

The majority of Level Four youth are in Department of Human Services' custody with either DCFS or DJJS. The Division case manager, along with the NOJOS certified sex-specific clinician and proctor/foster parents, work together to monitor the youth's compliance at home, school and in their sex-specific therapy. Additionally, in some cases, Level Four youth receive additional tracking services to increase monitoring and social support. If/when the youth's family is actively involved in the youth's care, and especially when the youth is to be eventually reunified with their family of origin, the parent(s)/guardian(s) must be involved in the treatment process. The parent(s)/guardian(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS Certified Clinician and Division case manager once the family is educated on the youth's risk and supervision needs and a family safety and supervision guideline plan has been developed.

Criteria for Discharge:

The youth may be successfully discharged from proctor/foster care when the NOJOS certified sex-specific clinician, parent(s)/guardian(s) and Division case manager determine that the youth's problem behaviors are manageable in a less-restrictive setting and the family is able and willing to provide adequate supervision. Parent(s)/guardian(s) must demonstrate they can

provide adequate supervision before the youth can be returned to their care. Transfer to a Level Two outpatient sex-specific treatment program can allow the youth to continue to address sex-specific treatment goals. Treatment professionals should be careful to coordinate the transfer of treatment services and keep parents adequately informed.

As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention; however, as stated above, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Four youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills have improved;
6. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
7. Protective factors, resiliency, internal and external assets have been increased; and
8. Progress has occurred on sex-specific treatment goals.

The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52).

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

Level Five
Sex-Specific Group Home or Independent Living / Sex-Specific Treatment

Client Profile:

Level Five youth present as ***moderate risk*** as assessed by nationally-recognized risk-assessment tools and includes two categories: Sex-Specific Group Home and Independent Living.

Sex-Specific Group Home

Level Five Sex-Specific Group Home intervention provides targeted sex-specific treatment in a therapeutic group-home setting. The primary differences between a Level Four Proctor/Foster Home and a Level Five Sex-Specific Group Home or Independent Living program is the intensity of therapy, increased opportunity for milieu intervention and increased supervision. Level Five programs provide additional clinical services, and the group home has twenty-four hour (awake) supervision and intervention.

Those youth who have successfully completed a higher level of care, such as a Level Six or Level Eight, may transition to a Sex-Specific Group Home or Independent Living, where they continue to be monitored and supported in a structured setting and receive targeted sex-specific treatment. Also those youth in lower level programs who are not progressing or have increased risk may be moved to a level 5 program with the court's direction.

Clinicians must observe special precautions when they select youth for Level Five sex-specific treatment and supervision. The client profile for youth placed in a Level Five Sex-Specific Group Home is similar to that of a Level Four youth, with some important distinctions, as outlined below:

Those factors SIMILAR to Level Four youth in that there are deficits and problems in the home environment:

1. Deficits or issues within the home environment:
    a. Family system and/or home environment is marked by extreme stress or instability, and it is determined that this stress and instability will not provide the support or supervision the youth needs to address his or her treatment and/or supervision needs;
    b. The adults are incapable of, or choose not to, provide the level of structure and supervision required to prevent re-offense or assist the youth to deal with his/her treatment needs;
    c. The family through their own behaviors, values and issues does not provide a healthy environment for youth to heal;
    d. The family presents as enabling and/or denial-based;

e. The family does not possess the skills or resources necessary to address the youth's clinical needs (i.e. skills enhancement, behavioral modification, regulation of co-morbid mental health issues, regulation of impulsivity, emotions, and behaviors).

Those factors that DIFFER from a Level Four or Level Six youth:

1. The youth not only needs removal from their home environment due to environmental and family risk factors, but also present with greater problems and deficits in executive functioning and behavior management;
2. These youth are also under-socialized, or have social-competency issues and social-relatedness issues, and have difficulty in developing the skills necessary to master and be successful in their environment. These deficits require a sex-specific group home setting and peer milieu to learn pro-socialization and healthy social skills. The group home setting is also necessary to provide the youth more structured opportunities to practice, improve and generalize new skills;
3. Less-developmentally mature than a Level Six youth, (meaning their developmental -maturity level may place them at-risk in a Level Six program.); they need clarity around language-related to risk and vulnerability versus immature highly sexualized risk;
4. Present as more amenable or receptive to treatment than a Level Six youth;
5. Present with difficult temperament traits as indicated b:
   a. Unmanaged or uncontrolled activity such as restlessness or impulsivity;
   b. Unpredictable emotional response/inconsistent emotional lability;
   c. Difficulty in dealing with change;
   d. May not respond appropriately to stimulus;
   e. Hyper-focus (perseveration);
   f. Distractibility;
   g. Inability to limit on-going behavior;
   h. Inability to adjust to change;
   i. Negative Mood (typical affective-state-positive, negative, or neutral);
6. History of, and/or current, behavioral-management issues in their home and/or school environment—unmanageability cannot be controlled in a less-structured environment. A behavioral-management program is required;
7. Under-socialized and/or multiple social competency deficits;
8. Self-harm behaviors;
9. Difficulties with executive functioning that require a peer milieu to learn control and self-regulation.

Sex-Specific Independent Living

Level Five youth who qualify for a sex-specific independent living program present with sexual behavioral issues and are typically older adolescents in need of a transitional placement to assist them in transitioning directly into adult living. Sex-specific independent living programming should specifically assist these youth to integrate and generalize their newly-acquired skills, or to develop such skills, to live independently in the community. These are youth who are either transitioning from a higher, more structured NOJOS level of treatment, or are youth without familial support from a lower level program who need to learn to live independently. Prior to placement, risk should be reassessed to determine that independent living in the community is appropriate.

Treatment Goals:

Overall, the treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically, while lowering risk of sexual re-offense. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, and stabilization of behavior in social, school and home setting. Risk Need Responsivity should be addressed (see page 7).

This Level also includes youth who have participated in a sex-specific treatment program and have been successful to the point they now need to integrate their new competencies and skills into an independent living setting and healthy emancipation.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way, and place themselves back on a healthy pathway towards becoming a functional, healthy, happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented on pages 14-15.

Sex-Specific Group Home

The focus of a Level Five Sex-Specific Group Home treatment program is to provide primary sex-specific treatment similar to lower level treatment frequency and modality; but enhanced through therapeutic milieu and skills development components. However, it provides adjunct mental-health treatment and social skills services to address pre-existing mental health issues and psychosocial problems, and to provide prosocial skills training to increase social competence. Level Five group homes also provide a structure and therapeutic milieu that address the youth's individual issues and need for pro-socialization through guided peer interaction and milieu intervention. Level Five Sex-Specific Group Home settings specifically help these youth learn to regulate their behaviors and emotions, control impulses, make healthy choices, learn consequences for unhealthy choices, increase personal accountability and become more socially competent.

Sex-Specific Independent Living

The treatment focus for Sex-Specific Independent Living is to aid the youth to develop independent and adult-living skills, such that they can successfully reintegrate into the community and establish a healthy support system. Often times this includes providing therapeutic assistance to help the youth individuate from parent(s)/guardian(s) and solidify a healthy young-adult identity.

Treatment Modalities and Frequency:

Sex-Specific Group Home

Overall, treatment objectives should be holistic and include specific goals, tasks, and methods to address the youth's sex-specific, (co-occurring issues) and skills-development services. Sex-Specific Group Home programs are required to provide specialized sex-specific supervision and treatment; however, the frequency and intensity varies based on the population served and the individual need of each youth. Level Five programming should include targeted sex-specific treatment (individual, family and group therapies), competency and skills development services and traditional mental health counseling, as well as medication management services.

Parent groups/family therapy should occur at least bi-monthly. Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, supervision, safety and assisting the youth to manage his/her risk, as well as strengths and healthy living plans. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. Special attention should be focused on the "strengths" inherent in the youth and his family as well. It is important to view the parent/guardian as part of the treatment team and empower them to be an active participant in the youth's treatment. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues.

SCHOOL PROGRAMMING should be based on the youth's risk to the community and his/her educational needs (i.e. may include Sex-Specific Day Treatment, Youth-In-Custody (YIC) classroom, Behavior Disorder (BD), public school, etc.). Reference the school protocol addendum of this manual.

Sex-Specific Independent living

Independent living can occur in an individual home setting. These programs are required to provide sex-specific treatment involving the themes listed and with the modalities, goals and frequency outlined for Level Five. Additional independent living skills development opportunities and interventions are a primary and significant focus as well

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be credentialed by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as the neurophysiology and etiological (including maintenance factors) impact on developmental trajectory.

Those individuals providing skills-development services or other skills-based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be credentialed by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the

supervision of a NOJOS credentialed sex-specific clinician.

Monitoring:

The majority of Level Five youth are in Department of Human Services' custody through either Division of Child and Family Services or Division of Juvenile Justice Services. The Division case manager, along with the NOJOS credentialed sex-specific clinician and group home staff, work together to monitor the youth's compliance in the group home, school setting and in their sex-specific therapy. Additionally, in some cases, Level Five youth may receive additional tracking services to increase monitoring and social support. If/when the youth's family is actively involved in the youth's care, and especially when the youth is to be eventually reunified with their family of origin, the parent(s)/guardian(s) must be involved in the treatment process. The parent(s)/guardian(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS credentialed clinician and division case manager once the family is educated on the youth's risk and supervision needs and a family safety and supervision guideline plan has been developed.

Educational/school placement should be guided by school district policy and the NOJOS Placement Protocol.

Criteria for Discharge:

Networking and case coordination are essential to track the youth's treatment progress and preparation for placement and discharge. There should be consensus between the placement and treatment teams that the goals for treatment and success are being met. If there is conflict, programs should always error on the side of caution and follow currently-accepted national assessment and treatment standards and NOJOS protocols. Transfer to an outpatient-treatment program is appropriate when the youth has progressed sufficiently in a Level Five treatment program. This once again supports the step-up step-down model. The length of treatment in a Level Five facility is based on individual "Risk, Need and Responsivity". Lack of treatment progress may result in referral to more intensive treatment and/or supervision, and may also result in increased length of treatment.

Criteria for treatment progress include the accomplishment of the treatment goals and objections and demonstrating the implementation of desired skills and behavioral changes in observable behavior

Level Five Sex-Specific Group Home supervision and treatment has an indeterminate length, and depends on the varying progress and needs of the youth. As deemed appropriate, once a youth successfully completes Level Five Sex-Specific Group Home program, a step-down to a lower level sex-specific outpatient treatment provider or a referral to traditional mental-health services may be appropriate. As in any treatment level, lack of treatment progress may result in a referral to a more-intensive treatment intervention. However, as stated above, <u>all</u> changes in placement or clinical level should be based on increased or decreased risk as measured by nationally accepted risk assessment tools and approved by the court rather than *solely* on resistance and/or non-compliance.

It is recommended that Level Five youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-occurring issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills have improved;
6. Etiological and maintenance factors, as well as treatment issues identified at intake have been addressed;
7. Protective factors and resiliency, as well as internal and external assets, have been increased, and progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

Level Six: Sex-Specific Residential Intensive / Sex-Specific Treatment

Level Six programs serve higher-risk youth who engage in sexual misconduct with a broad range of sexual-offense behaviors and who are often sexually-preoccupied. These youth have serious and significant sexual acting out issues, potentially highlighted by patterned and repetitious behaviors. They may have persistent or fixated patterns of offending, use of force or weapons in committing their offenses and/or display a propensity to act out with same-aged peers in addition to their younger victims. These are youth with multiple vulnerabilities and deficits in their ability to meet their perceived needs in healthy ways. Treatment for these youth must go beyond the sexual problems and must focus on treating the entire person. Specifically, these youth have multiple deficits and vulnerabilities in several categories—these issues make up the youth's etiological and maintenance factors:

1. Developmental issues—these youth have significant development issues as evidenced by:
    a. Failure or disruptions in the developmental stages;
    b. Attachment deficits;
    c. Learning disabilities;
    d. Intimacy deficits;
    e. Verbal expression deficits;
    f. Co-morbidity of mental health issues;
    g. Cognitive distortions.

2. Environmental issues—youth who come from difficult, unhealthy or negative environments as marked by:

    a. Negative family environment;
    b. Family instability, disorganization and violence;
    c. Poor child-rearing practices;
    d. Familial rejection, abuse and neglect;
    e. Lack of interaction between parents and child.
    f. Parental conflicts and disagreements;

g. Parental or familial separations ;
h. Socio-economic difficulties;
i. Parental criminality;
j. Parental substance-abuse issues;
k. Parental mental-health issues;
l. Negative peer influence.

3. Deficits in executive functioning—these youth have significant deficits in executive functioning resulting in problems with self-regulation as evidenced by:
4.

a. Emotional self-regulation problems;
b. General self-regulation problems;
c. Limited rules for appropriate social behavior and interaction;
d. Poorly-developed or primitive senses of morality;
e. Poorly-defined sense of personal boundaries and taboos;
f. Failure to understand consequences of their behavior;
g. Limited self-control over:
    i. ADHD;
    ii. Anger management;
    iii. Impulsivity;
    iv. Can be Conduct Disordered or Oppositional Defiant Disordered;
h. Difficulty in goal-directed actions;
i. Difficulty in monitoring, evaluation, selection and modification of behavior; Ineffective strategies and coping skills.

4. Cognitive distortions—their cognition is distorted, which has led to distorted beliefs and values and an underdeveloped and inadequate morality.

5. Emotional issues—these youth also experience significant problems in emotional identification, expression and regulation including:

a. Depression and anger issues;
b. Difficulty identifying, understanding and expressing emotions;
c. Limited emotional expression;
d. Inability to control intensity of emotion;
e. Inability to match correct emotion with the context and/or circumstances;
f. Inability to recognize internal and external emotional cues and non-verbal language;
g. Acting out their emotional experiences through negative or otherwise inappropriate behaviors.

6. Self-concept deficits—these youth present with problems and deficits in their self-concept and worth which includes:

a. Deficits in self-esteem, worth, independence and confidence; Misattributions or perceptions of self;
b. Deficits in autonomy and assertiveness; Deficits in self-satisfaction; unsolidified self-identity or solidification of identity around anti-social themes.

7. Social competency and social relatedness deficits—deficits in social competency and social relatedness result in a lack of skills necessary to master their environments and succeed in social relationship and intimate connections. Issues related to spectrum disordered clients should have an approach that is sensitive to their learning and development styles. Spectrum clients may be integrated with neuro-typicals but there should be adaptation and awareness of their individual needs. Providing social safeguards and staff awareness in these cases is important.

8. Childhood maltreatment—they have experienced significant childhood maltreatment and trauma including:
   a. Neglect and lack of appropriate attachment and bonding; Sexual, physical and psychological abuse;
   b. Exposure to domestic violence; Bullied, ridiculed and teased; Isolated and rejected.

9. Awareness deficits—they possess awareness deficits highlighted by:

   a. Lack of empathy; Lack of concern for others; Little remorse for behaviors; Little insight into the needs and feelings of others;
   b. Place own needs and feelings ahead of needs and feelings of others; Narcissistic qualities.

In addition, these youth often have additional co-morbid mental-health issues and learning disabilities, and many also have a prior treatment history and/or legal involvement.

Level Six youth present a significant risk for re-offending sexually, and thus, require intervention in a structured and restrictive residential treatment setting. These youth possess multiple risk, etiological and maintenance factors—it is these factors that place all youth on the pathway to sexually offend; however, Level Six youth have *more factors expressed at a higher level of intensity*. Due to the manner in which these youth sexually offend and the number and variety of etiological and maintenance factors identified in these youth, they score in the ***moderate-to-high and high risk*** range on acceptable national risk assessment tools. They possess risk too great to remain in the community or be placed with less-sophisticated youth in Level Five settings. They are youth in need of intensive structure, treatment and supervision in order to address their sexual-acting out issues and other vulnerabilities, deficits and treatment needs. These youth usually require more-intensive intervention than provided in less-intensive programming. These youth may be extremely opportunistic and aggressive toward others and may show predatory patterns. Many exhibit severe psychiatric problems but are not usually thought-disordered or dissociative (thought-disordered youth are more appropriate for Level Seven).

Because of the elevated risk for acting out and exploiting others, educational settings for Level Six youth should be clearly structured and contained. There should not be co-mingling with general school populations and often educational needs will be met within the confines of the unit where they reside. That stated, as a youth demonstrates safety and is working towards transition and integration into the community, it may be appropriate with coordination, safety planning, and student commitment towards success to integrate these students into less restrictive educational

settings. This should be based on the needs and abilities of the school and the student to support a safe and structured transition.

Those factors that DIFFER from a Level Five youth include:

1. Present as more developmentally mature than a Level Five;
2. Present with an unwillingness to alter or "give up" inappropriate sexual interests/attitudes;
3. Present with entrenched difficult temperamental traits, denial and defensive personality structure;
4. Have demonstrated a high level of manipulation, sophistication and/or impulsivity;
5. Display more aggressive, conduct disordered or antisocial attitudes/behaviors;
6. Evidence persistence in sexual behavior and premeditation;
7. Present as less amenable or receptive to treatment than a Level Five youth;
8. Have received prior outpatient treatment;
9. Have reoffended sexually after initial sanction;
10. Have displayed lapse(s) in judgment or sexual behaviors (i.e. increased masturbation or pornography use, excessive interest in, and association with, children, etc.) while in a lower level of care;
11. Exhibit negative or unhealthy psychosocial stressors with peers;
12. Present with highly-manipulative, predatory or fixated patterns of offending;
13. Have a propensity to sexually act out with same-aged peers in addition to their younger victims;
14. Demonstrate sexual preoccupation, obsession and/or deviant sexual interests;
15. Display an acute psychiatric disturbance (chronic psychiatric disturbances are more appropriate for Level Seven);
16. Demonstrate psychopathic or antisocial tendencies;
17. Have higher frequency and duration of offending (typically greater than six months);
18. Have multiple and indiscriminate victims;
19. Have a high degree of intrusive and diverse sexual-offending behaviors;
20. Used force/intimidation in offending;
21. Present with co-existing behavioral/emotional problems (dual diagnosis);
22. Display other criminal behavior or antisocial thinking;
23. Progression from less-intrusive to more-intrusive offense behaviors;
24. Have received prior adult sanctions for sexual misconduct;
25. History of interpersonal aggression;
26. Poor self-regulation;
27. Greater propensity to abscond from a less-restrictive setting;
28. Present a significant risk to the community.

These youth may have also failed in a lower NOJOS level program or present a risk to the community that requires higher-intensity supervision and treatment. Adjudication of these youth is mandatory.

Treatment:

A Level Six program is a twenty-four-hour intensive community-based residential treatment program. It provides maximum, non-secure supervision and intensive clinical intervention. It is

not a locked facility but is staff secure. Level Six residential treatment differs from lower levels of treatment, in that Level Six residential treatment is more clinically-intensive and treatment services occur more frequently. Treatment includes empirically-validated sex-specific models and techniques that are nationally accepted and regularly updated (i.e., cognitive-behavioral, risk/needs and strength-based rehabilitation treatment).

As noted earlier, NOJOS' Level Six treatment philosophy, consistent with national literature, endorses the use of a holistic/integrated approach to treating youth who engage in sexual misconduct. This approach blends traditional aspects of sex-specific treatment into a more holistic and developmentally-consistent model for working with youth. Treatment not only focuses on the sexual problems, but also addresses the youth's growth and development, health, social skills, resilience and interventions focused on resolving the youth's own victimization and co-occurring disorders. The primary aim is to instill in the youth the knowledge, skills and competencies necessary to develop and implement a positive identity revolving around personally-meaningful ways of meeting their human needs and pursuing their interests. As part of this holistic approach, treatment should integrate standard sex-offense-specific treatment components, such as development of full accountability for all offense behaviors, insight into offense dynamics and choice to offend, building realistic and effective self-regulation/relapse-prevention strategies, develop a family safety plan, develop healthy sexual attitudes and boundaries and develop and sustain victim empathy.

Treatment should include sex education and healthy sexuality work, life-skills training, skills-development training, independent-living skills and psychiatric/medication management services. A psychosexual-education emphasis is also recommended to provide the youth with information regarding maturation, human development, healthy sexual functioning and the current laws regarding sexual conduct.

Additionally, trauma-specific treatment interventions should be utilized with those youth who present with an unresolved trauma history. It is strongly recommended the youth have opportunities to resolve his/her own childhood victimization with sensory interventions, *separate from* focus on his/her sexual offending to assist him/her to resolve his/her trauma, enhance his/her emotional coping skills and develop a healthy sexual identity.

Treatment Goals:

Level Six treatment must include targeted sex-specific therapy to include individual therapy, group therapy and family therapy weekly to provide the youth with information regarding healthy sexual functioning and prevent further development of his/her sexual misconduct while increasing healthy living skills. Level Six programs should also be capable of providing offense-specific risk and clinical evaluation. Treatment services include sex-specific treatment, psycho-social education and training groups in daily living and social skills, healthy sexuality and psychosexual education, family therapy, individual therapy, group therapy, psychological evaluation and testing, psychiatric evaluation and, as deemed appropriate, medication management.

Specific treatment goals for this level include increases in the offender's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to

these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment and stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way, and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

Treatment Modalities:

Level Six programs are staff-secure, community-based facilities either freestanding, or a more controlled unit within an overall residential campus where resident activities and movements are controlled or monitored by staff on a twenty-four-hour basis, and there is a strong emphasis on structure, intensive behavior management and containment. These facilities typically provide on-site schooling, as well as frequent and intensive psychological or psychiatric services delivered by on-site professional staff. These facilities rely upon behavioral systems or level systems to gain compliance from residents.

For youth who require placement in a Level Six, intervention to decrease sexually-abusive behavior problems is an integral part of an overall structured program. Individual, family, group and recreational therapies, as well as the therapeutic milieu intervention, provide the basic structure. Additionally, the youth participate in group therapy that focuses on sex-offending issues. Level Six youth typically cannot be adequately treated in a non-sex-specific or traditional residential program where the client population is insufficient to create a homogeneous group for youth with sexually-abusive behavior problems.

The treatment of youth who engage in sexual misconduct requires specialized training and a unique treatment approach. At a minimum, Level Six treatment should include the following treatment modalities and components:

1. Sex-specific group therapy two to three times per week focused on allowing the youth to work on accomplishing the treatment goals and expectations of sex-specific treatment with the support of a peer group;

2. Pattern and behavior work focusing on the identification and understanding of contributing factors (thought, feelings and behaviors) that occur before, during and after a youth's sexual misconduct, and development of coping strategies specific to each factor to interrupt unhealthy cycles and establish a relapse-prevention/self-regulation plan for such factors;

3. Skills in the use of strategies to help the youth understand their sexual attractions and arousals, differentiate healthy from unhealthy sexual functioning and develop the self-regulation and coping skills to control deviant impulses;

4. Sex education and healthy sexuality development in individual therapy, and/or a psychosexual educational group setting, to teach the youth about human sexuality and enhance their understanding of developmentally expected, healthy, appropriate adolescent sexual unfolding and expression. NOJOS certified sex-specific clinicians should use a psychosexual education curriculum that specifically addresses the unique characteristics of youth who engage in sexual misconduct;

5. Life-skills training in a group setting centered on the mastery of life and social skills, and healthy living abilities. This group encompasses both social skills specific to this population and traditional independent-living skills. These groups can be facilitated by non-clinical personnel and are encouraged to take place at least three times per week;

6. Individual therapy one to two times weekly addressing both sex-specific and more general psychological issues and needs;

7. Family therapy will be completed ideally on a weekly basis (as determined appropriate by clinician). Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, supervision, safety and assisting the youth to manage his/her risk, as well as plans for healthy living. Family therapy should also include education of the parents/caregivers regarding the youth's current risk factors, treatment goals and supervision needs. Under certain circumstances it may be appropriate to use phone or visual contact options (i.e. skype) when circumstances impede the ability to engage in person. All necessary disclosures when using unsecure networks regarding permission and respecting HIPPA laws must be clearly followed and documented;

8. Highly-structured academic programming (i.e., certified accredited self-contained classroom, sex-specific day treatment programming or youth-in custody educational programming);

9. Psychiatric and medication management.

Treatment Providers:

Those individuals providing targeted sex-specific therapy interventions, whether it is individual, family or group therapy, should be certified by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment, whether it is individual or group therapy, should be licensed mental-health clinicians with some experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. They also need to be aware of the influence of family, environment social and culture on the youth.

Those individuals providing skills-development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS certified sex-specific clinician.

Monitoring:

Level Six community-based placement provides maximum, non-secure supervision and intensive sex-specific clinical intervention. Youth in sex-specific residential placements are typically in the custody of the DCFS or DJJS. The juvenile justice authority, NOJOS certified sex-specific clinician and Level Six agency act as an intervention team to ensure the youth's compliance and progression in the treatment program. Level Six programs must be staffed at a ratio of one staff to three clients at all times with the exception of nighttime sleeping hours when staff may be reduced. However, at least two awake direct-care staff, or a ratio of one staff to five clients, must be on duty during nighttime sleeping hours. Level Six programs are required to provide twenty-four-hour wake supervision. The youth must be in line-of-sight supervision during all wake hours (excluding privacy time). Youth must be checked at least every fifteen minutes during nighttime supervision.

In a long-term sex-specific residential treatment program, youth are monitored therapeutically and by residential staff. If home visits are approved, parents are expected to report to staff following each visit.

Adjudicated youth are additionally monitored by the Juvenile Court and the Division of Juvenile Justice Services for compliance to treatment. When DCFS maintains custody or protective supervision of the youth, the DCFS caseworker also monitors compliance.

Criteria for Discharge:

Youth admitted to residential-intensive treatment have significant abusive-behavior patterns that require long-term treatment intervention. Length of stay in a Level Six treatment program averages twelve to eighteen months, with six to twelve months of follow-up aftercare services. However, some youth may stabilized more quickly, and based on progress and current assessment, step-down to a less restrictive level of care. Aftercare following Level Six placement may take place in an outpatient-treatment program with treatment goals and modalities similar to those given to Level Two youth, but specifically focused on assisting the youth to address issues related to their reintegration into the community. In this situation, Level Two provides a less-restrictive environment for transition and practice of skills learned in the Level Six intensive-residential program. It is imperative that treatment providers create a vision of transition as an extension of treatment so that there is not a period of disengagement based on the youth's belief that they have completed treatment. Level Six settings provide an outline of the hypothetical approach to transition which will require attention and redefinition based on the real life experience of the youth on the ground. This continuum approach has the potential to support the youth in long term success. Best practice is that professionals coordinate with one another through the change and if possible a transition session involving the Level Six and the step down provider and the youth will take place. This ideal creates continuity and supports the idea of the step down being an extension of the early intervention as opposed to starting over.

Criteria for treatment progress include: "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52). As in any treatment level, lack of treatment progress may result in a

referral to a more-intensive treatment intervention or level of care—in this case, incarceration in a Level Eight secure-care facility. However, as stated above, all changes in placement or clinical level should be based on increased or decreased risk as measured by nationally-accepted risk assessment tools rather than *solely* on resistance and/or noncompliance.

It is recommended that Level Six youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and/or reduced;
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized;
4. Risk has been lowered;
5. Level of functioning/skills has improved;
6. Etiological and maintenance factors, as well as treatment issues identified in the intake assessment, have been addressed;
7. Protective factors, resiliency, internal and external assets have been increased;
8. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-down.

Level Seven:
Inpatient Psychiatric / Sex-Specific Treatment

Client Profile:

Youth appropriate for Level Seven present with an acute or chronic psychiatric disturbance, are sexually impulsive, display unpredictable/uncharacteristic or pattern of bizarre/ritualistic offenses, unpredictable social behaviors and present a ***high risk*** to the community and/or the safety of other youth in lower level programming. Adjudication of these youth is mandatory.

These youth differ from Level Six and Level Eight youth based on their psychiatric disturbance. Their placement in Level Seven care is facilitated by their inability to manage their mental illness and are therefore in need of Level Seven placement to stabilize their psychiatric disturbance.

Treatment Goals:

It is important to note that the primary focus of Level Seven programming is stabilization of the mental illness, and not necessarily treatment for the sexually-abusive behaviors. Ideally, the sex-specific treatment should occur in a lower level of treatment subsequent to the youth's stabilization; nevertheless, sex-specific treatment should be initiated at this level of care, in conjunction with traditional mental-health counseling, until the youth has stabilized psychiatrically. Once transitioned to a lower level of care, the youth's sex-specific therapy should then be the primary focus in treatment. Treatment must also focus on management of problem behaviors (e.g., aggressiveness, impulsiveness or compulsive patterns of sexually-assaultive behavior).

Specific treatment goals for this level are those identified by the National Task Force on Juvenile Sexual Offending (1993). These goals include increases in the adolescent's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically.

Treatment Modalities and Frequencies:

Level Seven programs are locked, controlled-access units, either freestanding or a more-controlled unit within an overall residential psychiatric campus, where the youth's activities and movements are controlled or monitored by staff on a twenty-four-hour basis, and there is a strong emphasis on structure, intensive behavior management and containment. Level Seven facilities provide on-site schooling as well as frequent and intensive psychological and/or psychiatric services delivered by on-site professional staff. These facilities often have seclusion and restraint capacity and rely upon behavioral systems or level systems to gain compliance from residents (*Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52-53).

Level Seven sex-specific interventions are integrated into a more general psychiatric structured program. Therefore, traditional mental-health services are required, including individual, family and group therapy, as well as psychiatric and medication-management services. Therapy interventions are designed to address more general psychiatric issues and provide a solid

foundation for understanding and addressing related sexual issues/problems. However, the youth should participate in regular sex-specific individual and group therapy that focuses on sex-specific issues. Further, unlike Level Six youth, if the client population is insufficient to create a group for the youth with sexually-abusive behavior problems, the clinician may address the youth's inappropriate sexual behaviors within individual/family therapy. Otherwise, sex-specific treatment modalities should be similar to Level Six treatment modalities. The clinician who provides the therapy must be a NOJOS certified sex-specific clinician.

Given that the primary focus of Level Seven treatment is to assess and treat the acute or chronic psychiatric issues, once the youth's psychiatric disturbance is controlled/stabilized, the youth should be placed in a lower level of treatment.

Treatment Providers:

Treatment providers should have expertise and experience in working with adolescents with acute and/or chronic psychiatric problems/issues. They should also have training and experience in understanding how psychiatric issues interplay with adolescent sexual development. Those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified by NOJOS as a sex-specific provider. Individuals providing trauma-specific treatment (whether it is individual or group therapy), should be licensed mental-health clinicians with experience and training in working with youth who have been traumatized. Sex-specific treatment providers should have training in understanding adolescent development and trauma, as well as neurophysiology and etiological (including maintenance factors) impact on developmental trajectory. Additionally, they need to be aware of the influence of family, environment, social situation and culture on the youth.

Those individuals providing skills development services or other skills based groups (i.e. anger/aggression, mood management, prosocial skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS certified sex-specific clinician.

Monitoring:

In a NOJOS Level Seven treatment program, youth are monitored therapeutically and by residential staff. If home visits are approved, parents/guardians are expected to report to staff following each visit. Adjudicated youth are additionally monitored by the Juvenile Court and DJJS to ensure compliance with treatment. When DCFS maintains custody or protective supervision of the youth, the DCFS caseworker also monitors compliance.

Criteria for Discharge:

The youth may be successfully discharged from the Level Seven program and transitioned to a lower level of care when the youth demonstrates:

1. Stabilization of the mental illness;

2. They are no longer a danger to self or others;
3. They do not present with active psychosis or thought disorder symptoms;
4. Improved problem-solving and emotional-regulation skills.

The NOJOS certified sex-specific clinician(s) and the juvenile justice monitoring team evaluate the youth's treatment progress, assess risk and determine an appropriate aftercare placement.

Additionally, the parent(s)/guardian(s) must demonstrate understanding of the youth's sexually abusive behavior problems and an ability and willingness to supervise. Transfer to a lower level of clinical intervention (e.g., sex-specific residential intensive, sex-specific group home, proctor/foster care, day treatment or outpatient) is usually necessary to maintain changes achieved by inpatient hospitalization. Aftercare should provide the youth and family support.

If the youth has been adjudicated, or is receiving supervision from the juvenile court, the juvenile court personnel should be involved in placement decisions. Similarly, if the youth has been placed in the custody or protective supervision of the DJJS or DCFS, the Division case manager should be involved in placement decisions. Treatment professionals in both Level Seven and aftercare settings should be careful to coordinate the transfer of treatment services and keep parent(s)/guardian(s) adequately informed of all discharge plans.

It is required that Level Seven youth undergo a discharge assessment to determine if:

1. Mental illness has been stabilized;
2. Risk has been lowered;
3. They are no longer a danger to self or others;
4. Level of functioning has improved;
5. A stable support system has been developed;
6. Treatment issues identified in the intake assessment have been addressed;
7. Progress has occurred on sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

Level Eight:
Secure Care / Correctional Treatment Enhanced

Client Profile:

Level Eight youth have displayed repetitious, predatory, fixated and/or violent patterns of offending, use of force or weapons in their offenses and/or a propensity to sexually act out with same-aged peers in addition to younger victims. Level Eight youth may also display other criminality or non-sexual aggression that makes them too risky to maintain in a community placement. These youth also present with antisocial-interpersonal orientation or conduct-disorder behaviors that render them unable or unwilling to follow the structure and rules of community-based programs. These youth usually have a prior treatment history and have often failed previous placements and less-restrictive treatment options. Secure Care youth present an extreme risk to the community. Primary factors to consider are the higher frequency and degree of severity of the behaviors and/or the extended length of time the youth has exhibited these behaviors.

These youth differ from Level Six youth based on use of aggression in the offending;

- Violent patterns or use of force or weapons during the course of their offense;
- Overall criminality and non-sexual delinquency makes it difficult to maintain the youth in a community program;
- Aggression, acting out and/or AWOL risk cannot be maintained in a community-based program;
- Defined development of antisocial traits that make it difficult to treat the youth in the community;
- Failure in lower-level treatment programs.

Treatment:

Secure facilities are the final NOJOS level, and most secure confined settings, for youth who commit repetitive sexual and/or non-sexual-assault behaviors. Secure facilities are long-term, locked confinement facilities for serious and habitually-delinquent youths. Secure facilities have high security and multiple barriers preventing escape. These facilities provide some professional psychological or psychiatric treatment services and may use a level system. Participation in school or GED services is required for these youth. Behavioral change is often pursued via control and application of sanctions.

Delinquent youth are not sentenced for a specific length of time, but their stay is based on the guidelines established by the Youth Parole Authority. The Youth Parole Authority conducts regular progress reviews and determines when the youth can be released. Once the juvenile court orders a delinquent youth to a secure facility, the authority for the youth is transferred to the Youth Parole Authority. Juveniles placed in secure facilities must receive educational and vocational services. Each juvenile must complete an individually-designed treatment plan based on their rehabilitative needs, and they must complete the court-ordered victim restitution as part of the requirements for release. Youth In Custody (YIC) teachers, who are employed by the school districts, hold daily classes for youth. Schoolwork finished in secure facilities is credited

to the youth's regular academic record (http://www.jjs.utah.gov/secure- facilities.html).

In locked, correctional settings, treatment is often considered a privilege, even though in many ways these youth present the greatest need for treatment intervention in order to return to a normative path of development and rehabilitate. National literature indicates youth refusing to meaningfully participate in treatment over reasonably-appropriate periods of time should be discharged from treatment groups and not be provided with additional benefits or perquisites. They should also be required to serve the maximum sentence imposed by a judge. However, the option of participating in treatment should be available to these youth at any time during their incarceration (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse*, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 53-54).

Treatment Goals:

The treatment goals for this levels include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home setting.

Overall, the goal is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006).

A full list of Sex-Specific Treatment Goals is presented on pages 14-15.

Treatment Modalities:

Secure facilities provide correctional programming enhanced with sex-specific and trauma-specific treatment modalities similar to a Level Six program. Secure care treatment focuses on the following:

- Sex abuse prevention;
- Community protection;
- Rehabilitation;
- Development of a healthy non-offending self-identity.

Secure treatment modalities include targeted sex-specific therapy to include individual therapy and group therapy weekly to provide the youth with information regarding healthy sexual functioning and prevent further development of his/her sexual deviancy. If reunification is the goal, and/or family issues are a significant part of the youth's problems, family therapy should also be provided if possible. With older adolescents, individuation issues should be addressed to assist the youth to move toward young adulthood and emancipation.

Treatment should include sex education and healthy-sexuality work, life-skills training, skills-development training, independent-living skills and psychiatric/medication management services. A psychosexual-education emphasis is recommended to provide the youth with information regarding maturation, human development and the current laws regarding sexual conduct.

Trauma-specific treatment should also be available for those youth who present with an unresolved trauma history. It is strongly recommended the youth have opportunities to resolve his/her own childhood victimization with sensory interventions *separate from* focus on his/her sexual offending to assist him/her to resolve his/her trauma, enhance his/her emotional coping skills and develop a healthy sexual identity.

Treatment Providers:

Those individuals providing Level Eight targeted sex-specific services, whether it is individual, family, or group therapy, must be certified by NOJOS as a sex-specific clinician. Individuals providing trauma-specific treatment, whether it is individual/group therapy, should be licensed mental health clinicians with experience and training in working with youth who have been traumatized. Sex-specific treatment providers should also have training in understanding adolescent development, trauma and neurophysiology and etiological and maintenance factors impact on developmental trajectory. Additionally, they need to be aware of the influence of family, environment, social and culture, on the youth.

Those individuals providing skills-development services or other skills-based groups (i.e. anger/aggression, mood management, pro-social skills, etc.) must be trained and competent to provide the service; however, although they are not required to have a clinical license or be certified by NOJOS, it is recommended that they have attended and completed the NOJOS Basic Line Staff Training. Regardless, providers of these adjunct services should work under the supervision of a NOJOS certified sex-specific clinician.

Monitoring:

Secure confinement provides maximum supervision of the most dangerous sexually-abusive youth and intensive sex-specific clinical intervention. The Juvenile Court places custody of the juvenile with the Youth Parole Authority. The Youth Parole Authority (through DJJS), the

NOJOS certified sex-specific clinician(s) and the correctional facility's clinical team monitor the youth's compliance and progress in the treatment program.

Criteria for Discharge:

Length of stay in a secure facility typically ranges from eighteen to twenty-four months. The clinical intervention team and the Juvenile Justice case manager monitor treatment progress and determine when the youth is eligible for release to a less-restrictive level of care. The Youth Parole Authority must approve release. Depending on risk potential, the youth may then transfer to residential-intensive (Level Six), sex-specific group home (Level Five), proctor care (Level Four) or outpatient treatment (Level Two). The combined length of treatment in secure confinement and aftercare settings ranges from eighteen to thirty months. If the youth fails to respond to treatment in secure confinement, certification into the adult system may also be an option.

Criteria for treatment progress include: "Accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time" (National Task Force on Juvenile Sexual Offending, 1993, p. 52). The progress indicators established by the National Task Force on Juvenile Sexual Offending are also useful to evaluate treatment progress (The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of The National Adolescent Perpetrator Network, *Juvenile and Family Court Journal*, 1993, Vol. 44, No. 4, page 52) Lack of treatment progress may result in extended duration of confinement or more-restrictive parole considerations.

It is required that Level Eight youth undergo a discharge assessment to determine if:

1. Risk has been lowered;
2. Co-morbid issues have been addressed/stabilized;
3. Level of functioning has improved;
4. A stable support system has been developed;
5. Treatment issues identified in the intake assessment have been addressed;
6. Progress has occurred on sex-specific and non-sex-specific treatment goals.

As detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-up or step-down in the NOJOS continuum.

Latency Age Children who Sexually Act Out

Treatment Standards for Children with Sexual Behavior Problems

Children who engage in inappropriate or abusive sexual behaviors are developmentally unique from adolescents and adults who engage in illegal sexual behaviors. "It has become crystal clear that children with sexual behavior problems are not just miniature versions of adults and adolescent sexual offenders (Johnson & Doonan, 2006, p. 109)." There is evidence that interventions which evolved from adult sex offender treatments are not effective in reducing sexual behavior problems in children (Amand, Bard, & Silovsky, 2008). Consequently, interventions traditionally used with adolescents and adults are often inappropriate for children who are best served by treatments tailored to their developmental needs. This section will discuss appropriate care and treatment guidelines for children twelve years old and younger who have engaged in inappropriate sexual behaviors.

Sexual behaviors are a common part of childhood. Research has shown that children "exhibit numerous sexual behaviors at varying levels of frequency (Friedrich et al., 1998, p. 6)." At various points in development certain child sexual behaviors may be considered expected or "normal" in developmental terms (Friedrich, 1997). However, some children engage in sexual behaviors that are inappropriate, intrusive, and/or abusive.

Professionals assessing child sexual behaviors face an important question: "Does the nature of the sexual behaviors warrant intervention, and if so, what form of intervention is appropriate?" Determining the significance of a child's sexual behavior and risk for further problems usually requires consideration of a variety of potentiating and protective factors related to aspects of the sexual behaviors, the child's history of abuse, family features, and child features (Friedrich, 2007). Two instruments have been developed to assess sexual behaviors in children: 1) the Child Sexual Behavior Inventory (CSBI) (Friedrich, 1997) and the Child Sexual Behavior Checklist (CSBCL) (Johnson 2003). Clinicians making decisions regarding the need for intervention and treatment are best served utilizing these instruments. Therapists who do not have access to these instruments may access useful guidelines from the National Center on the Sexual Behavior of Youth (NCSBY) which can be found at http://www.ncsby.org/.

If it is determined that a child's sexual behaviors warrant intervention, then treatment services should be tailored to the child's developmental level. There is evidence that treatments utilizing cognitive behavioral therapy are more effective in reducing recidivism in children and youth who have engaged in sexually abusive behaviors than more non-directive play therapy approaches (Carpentier, Silovsky, & Chaffin, 2006). However, for children, interventions which include the parent/caretaker appear essential. "Children are embedded in their families and for treatment to be successful, the parents must change how they relate to the child. Only then can the child adopt a new, non-sexualized interpersonal model. Thus, outpatient treatment that involves the parent should be viewed as the treatment of choice (Friedrich, 2007,pg..13)." Amand, Bard, and Silovsky (2008) found five practice elements (parenting/behavioral management skills, rules about sexual behavior, sex education, abuse prevention skills, and self-control skills) had the most significant impact in reducing sexual behavior problems in children. "The Parenting/Behavior Management Skills was by far the practice element most strongly

associated with reduced SBP (sexual behavior problems) (p.161)." They further suggest, "….the results emphasize that the primary agent of change for (sexual behavior problems) appears to be the parent or caregiver (p.161)."

The following guidelines will discuss treatment protocols and standards for children who have engaged in inappropriate sexual behaviors. "Children with sexual behavior problems are a diverse group (Friedrich, 2007, p. 35)." Thus, terminology for categorization developed by Hall, Mathews & Pearce (2002) will be used to organize this discussion. Their study identified the following categories of child sexual behaviors in abused children:

- Developmentally "expected" sexual behavior
- Developmentally problematic: self-focused sexual behavior
- Developmentally problematic: unplanned, interpersonal sexual behavior
- Developmentally problematic: planned, interpersonal sexual behavior
- Developmentally problematic: planned, coercive, interpersonal sexual behavior

Each section will outline a client profile, treatment goals, treatment modalities and frequencies, requirements for treatment providers, and criteria for discharge. Also, due to the significant variations in development across childhood, this discussion will address treatment issues in terms of younger children (ages 4-7) and older children (8-12) when appropriate.
Developmentally "Expected" Sexual Behavior

Developmental "Expected" Sexual Behavior

Client Profile

This profile would account for children who engage in sexual behaviors considered to be common for their own chronological age or developmental level. The sexual behaviors usually function as a means to gather information such as exploring bodies in a visual or tactile manner. These behaviors may be self-focused (e.g., a child examining their own private parts) or involve other children. If the sexual behaviors are interpersonal, participation is voluntary, the behaviors occur spontaneously, and only involve children of similar age, size, and developmental level. These behaviors tend to be "light hearted," motivated by curiosity, and do not result in distress for the child/children involved. These behaviors occur in low frequency and typically cease when appropriate education is offered, rules and limits are established, and adequate supervision is provided.

Treatment Goals

- Provide needed age appropriate psycho-education. For younger children this would include information on bodies, the meaning of personal/private, information on appropriate touches, and boundaries. In some cases, older children may benefit from sex education to include sexual anatomy and maturation.
- Teach safety skills such as body ownership, reporting abuse or inappropriate behaviors, stranger safety, and internet safety skills.

- Establish compliance to sexual behavior rules.
- Help parents/caretakers develop a "vocabulary" needed to communicate with their child about sexual issues in an age appropriate and effective manner.
- Educate parents/caretakers on how to effectively respond to their child(s) sexual behaviors.
- Help parents effectively and appropriately respond to their child's sexual behaviors.
- Ensure parents are providing adequate supervision to reduce the risk for on-going problems.

Treatment Modalities and Frequency:

In cases where parents are able to provide appropriate education and supervision, mental health services may not be warranted. However, most children in this profile may benefit from short term services to include individual and family therapy (weekly or bi-weekly) for approximately 4-12 sessions.

Treatment Providers:

Clinicians providing these services should be licensed mental health treatment providers who have training in child development and experience working with children and families. If the person is not a licensed mental health provider they must be trained and competent to provide the service and be supervised by a licensed mental health provider.

Monitoring:

Typically participation in treatment in these cases would be voluntary. Parents/caretakers are responsible for their child's participation in treatment and for providing adequate supervision to reduce the risk for further problems.

Criteria for Discharge:

- Children have demonstrated understanding of the concepts learned in psycho-education.
- Children are complying with the sexual behavior rules.
- Parents are able to communicate in an age appropriate manner with their child regarding sexual behaviors and sexual issues.
- Parents are providing sufficient supervision and structure.

Developmentally Problematic: Self-focused Sexual Behavior

Client Profile

This profile would account for children who engage in sexual behaviors that are "self-focused" but result in behavioral or social difficulties. These children do not have a history of engaging in sexual behaviors involving other children. Self-focused behaviors usually involve

compulsive masturbation or inserting objects into their private parts. In some cases, these behaviors may result from the child becoming highly sexualized as a result of exposure to sexual stimuli (e.g., sexual arousal experienced during abuse, exposure to pornography, witnessing adults engaged in sexual acts). Other children may compulsively touch their private parts as a means of coping with non-sexualized stressors such as anxiety. Some children engage in compulsive masturbation because the behavior is reinforced by their parent's emotional reactions (either positive or negative). The behaviors become problematic when: 1) the child spends too much time engaged in the behavior at the expense of other more healthy activities, 2) the behavior causes difficulty in the parent-child relationship or other social relationships, and/or 3) the behavior results in bodily pain or injury.

Treatment Goals

- Identify the motivational source for the development and maintenance of the behavior and help the child develop healthy means to get their needs meet.
- Reduce the frequency of the problematic behavior to the point it becomes consistent with the family values and/or eliminates behavioral or social difficulties.
- Establish sexual behavior rules with the child and parents/caretakers.
- If the behavior appears to result from trauma, use a trauma focused and approved treatment such as Trauma-Focused Cognitive Behavioral Therapy developed by Cohen, Mannarino, and Deblinger (2006).
- Teach the child self-regulation and self-control skills such as relaxation, thought replacement, re-direction activities, problem solving or self-talk skills. Also, teach the child how to effectively solicit support from his/her parent/caretakers when needed.
- Teach parents/caretakers to coach or cue their child to use the self-regulation skills and effectively provide support when solicited or needed.
- Help parents/caretakers develop an effective behavioral management strategy to contain, reduce or eliminate the behavior in a positive and supportive manner. Such strategies may include the use of positive reinforcement, mystery motivators, selective attention/ignoring, or token systems.
- Improve the parent-child relationship by increasing the frequency of positive interactions with their child. For example, the child directive interventions derived from Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010).

Treatment Modalities and Frequency:

Most children in this profile may benefit from therapy on a weekly basis. Services may last between 4-15 sessions. In cases where the behavior derives from a history of abuse or trauma, or the behaviors have resulted in significant conflict in the parent-child relationship, the length of treatment may be longer.

Treatment Providers:

Clinicians providing these services should be licensed mental health treatment providers with training in child development, have experience working with children and families using evidence based trauma focused treatments, and competence in teaching effective behavioral management strategies. If the person is not a licensed mental health provider they must be trained and competent to provide the service and be supervised by a licensed mental health provider.

Monitoring:

Typically participation in treatment in these cases would be voluntary. Parents/caretakers are responsible for their child's participation in treatment and for monitoring and reporting on treatment progress.

Criteria for Discharge:

- The frequency of the behavior has declined to the point it is no longer resulting in behavioral or social difficulties.
- The child is complying with the sexual behavior rules established.
- The child is effectively using self-regulation and self-control skills and/or accessing needed support from their parents/care providers.
- Parents/caretakers are able to provide positive support to their child when solicited or needed.
- Parents are effectively using behavioral management strategies to address their child's behavior.
- The frequency of positive interactions between the parent and child has increased.

Developmentally problematic: Unplanned, Interpersonal Sexual Behavior

Client Profile

This profile would account for children who engage in sexual behaviors deemed problematic and involve other children. These behaviors are impulsive, spontaneous and/or episodic. Typically, these behaviors are outside what would be expected for children given their age or developmental level. These children do not appear to be sexually preoccupied. The frequency of these behaviors is low and the number of other children involved is generally few. These behaviors can range from exposure of genitals to more "adult like" sexual acts. In some cases, these children may be reacting to their own victimization or exposure to adult sexuality. In other situations these behaviors may be a part of the child's general misbehavior or impulsivity. However, the sexual behaviors violate social norms and result in emotional or social difficulties for themselves and/or other children involved.

Treatment Goals

- Establish a safety plan with the child and his/her parents/caretakers to reduce exposure to risky situations and ensure adequate supervision during contact with younger or more vulnerable children.
- Establish rules for sexual behaviors with the child and parents/caretakers.
- Provide needed age appropriate psychoeducation (see above categories for details).
- If the child has been a victim of abuse or exposed to adult sexuality, reduce the associated symptoms and integrate those experiences in an adaptive manner through the use of an evidence based trauma focused treatment model.
- Ensure the child is honest and accountable for their misbehaviors.
- Older children will complete a narrative regarding their inappropriate sexual behaviors to include related thoughts, feelings, and dangerous situations.
- Enhance the child's emotional expressive skills and recognition of other's emotional states.
- Improve the child's ability to self-regulate and manage impulses (see previous categories for details).
- Establish appropriate physical and emotional boundaries.
- In older children, increase the child's understanding of his/her own internal processes (i.e., thoughts and feelings) and develop means to create internal change (e.g., self-talk, calming skills, thought stopping).
- If the situation is warranted, the child will make amends in a manner appropriate to anyone negatively impacted by his/her behaviors.
- Help parents effectively and appropriately respond to their child's sexual behaviors.
- Help parents/caretakers communicate about sexual issues in an age appropriate and effective manner with their child/children.
- Assist parents in developing effective behavioral management techniques (see previous categories for details).
- Improve the parent-child relationship.

Treatment Modalities and Frequency:

Most children in this profile will remain in the custody of their primary family system and benefit from individual and family therapy on a weekly basis. Group therapy may be helpful for children who have deficits in social skills. In cases where parents/caretakers are unable to provide adequate supervision or are unwilling to make necessary changes to reduce the child's risk, an out-of-home placement may be necessary. Services may vary depending on the risk and protective factors involved in the individual case. However, therapy may typically range from 3-6 months in duration. In cases where the behavior derives from a history of abuse or trauma, there have been family disruptions, or the behaviors have resulted in significant conflict in the parent-child relationship, the length of treatment may be longer.

Monitoring:

Parents/caretakers are typically responsible for their child's participation in treatment and monitoring progress. In some cases, DCFS may be involved and will determine if an out-of-home placement or further monitoring is warranted. If so, the DCFS case worker would have a role in monitoring compliance to the safety plan and participation in treatment.

Criteria for Discharge:

- The child is complying with the sexual behavior rules.
- The child and family are complying with a formal safety/prevention plan.
- The child is fully accountable for their behaviors and made amends when appropriate.
- Older children have completed a formal narrative regarding their own trauma history and/or sexual behavior problems without using cognitive distortions or experiencing undue distress.
- The child is effectively using self-regulation and self-control skills to maintain appropriate boundaries.
- Older children have increased insight into their own internal processes and developed coping skills to alter negative feelings and cognitive distortions.
- Parents/caretakers are able to provide positive support to their child.
- Parents/caretakers are effectively using behavioral management strategies.
- The frequency of positive interactions between the parent/caretaker and the child has increased.

Developmentally Problematic: Planned, Interpersonal Sexual Behavior

Client Profile

This profile would account for children who engage in sexual behaviors with forethought and planning, that are deemed problematic and involve other children. These children are usually older (age 7 and above). The sexual behaviors are frequently "adult like" sexual acts. These behaviors often involve victim selection (usually younger siblings and/or younger or more vulnerable children). These behaviors also involve a non-coercive "set-up" (e.g., creating situations where they can be alone with other children, promising other children treats for compliance to requests for sexual touching, or making sexual touching seem like a game). These children are often sexually preoccupied, have problems with other non-contact sexualized behaviors (e.g., compulsively masturbation and/or sexualized talk), and/or have sexual knowledge beyond what would be considered expected for their age. They typically exhibit a greater frequency of sexual behaviors and involve more children than the previous categories. Many of these children have been victims of sexual abuse and/or have been exposed to adult sexuality during which they experienced sexual arousal. The sexual behaviors violate social norms and result in emotional and/or social difficulties for themselves and/or other children involved.

Treatment Goals

- Establish a safety plan with the child and their parents/caretakers to reduce exposure to dangerous situations and ensure adequate supervision during contact with younger or more vulnerable children.
- Establish rules for sexual behaviors with the child and parents/caretakers.
- Provide needed age appropriate psycho-education (see previous categories for details).
- Improve the child's ability to effectively cope and manage dysregulating sexual thoughts and feelings (e.g., thought stopping, self-talk, seeking help from a primary attachment figure).
- Reduce symptoms related to the child's own history of abuse and/or exposure to adult sexuality by use of an evidence based trauma-focused treatment model.
- Enhance the child's emotional expressive skills and recognition of other's emotional states.
- Ensure the child is honest and accountable for their victim selection, "set up," and inappropriate sexual behaviors.
- Older children will complete a narrative regarding their inappropriate sexual behaviors highlighting the associated difficult feelings, thinking errors and dangerous situations.
- When appropriate, the child will make amends to anyone negatively impacted by their behaviors.
- Improve the child's social skills.
- Help the family establish healthy physical and emotional boundaries.
- Help parents/caretakers effectively and appropriately respond to their child's sexual behaviors.
- Assist parents/caretakers in effectively responding to and supporting their child's efforts to cope with dysregulating sexual thoughts and feelings.
- Help parents/caretakers communicate prosocial and healthy beliefs regarding sexuality with their child/children.
- Assist parents in developing effective behavioral management techniques (see previous categories for details).
- Improve the parent-child relationship.

Treatment Modalities and Frequency:

Some children in this profile will remain in the custody of their primary family; however, an out-of-home placement may be necessary if the child has engaged in inappropriate sexual behaviors with a younger sibling and/or their parents/caretakers are unable or unwilling to provide adequate supervision and comply with the safety plan. An out-of-home placement may also be necessary if the child was victimized or maltreated in the home or continues to be exposed or have access to sexualized stimuli. Treatment modalities should include individual and family therapy. When available, group therapy may be helpful in strengthening social skills. Additional wrap around services such as day treatment, respite, and/or after school

programs may also be warranted. Typically treatment lasts between 6 months to over a year in length. However, completion of treatment should be contingent on the child's and/or family's internalization and application of concepts and skills developed in therapy.

Treatment Providers:

Clinicians providing these services should be licensed mental health treatment providers with training in child development, have experience working with children and families using evidence based trauma focused treatments, and experience working with sex specific treatment. Therapists should also have a knowledge base in child development and have experience working with family systems and providing effective behavioral management training. If the person is not a licensed mental health provider they must be trained and competent to provide the service and be supervised by a licensed mental health provider.

Monitoring:

Parents/caretakers are typically responsible for participation in treatment and monitoring progress. When DCFS is involved, the caseworker will also monitor for compliance to the safety plan and treatment. In cases where the child has been displaced from the home, guardians or foster parents will monitor the child's progress and report to the caseworker and therapist working with the child and family. Children in foster care will also be monitored by the court system. Staff from other agencies providing wrap around services can also provide valuable feedback and ensure adequate supervision while in their care.

Criteria for Discharge:

- The child is complying with the sexual behavior rules.
- The child and family are complying with a formal safety/prevention plan.
- The child is fully accountable for their behaviors and has made amends when appropriate.
- Children have completed a formal narrative regarding their own trauma history and sexual behavior problems without using cognitive distortions or experiencing undue distress.
- The child is effectively using self-regulation and self-control skills to manage sexual thoughts and feelings (see previous categories for details).
- The child has developed and maintained age appropriate friendships and/or is successfully engaging in healthy social outlets.
- Older children have increased insight into their own internal processes and communicate negative feelings in a safe and appropriate manner, can alter cognitive distortions, and identify and manage dangerous situations
- The family system is maintaining healthy and appropriate physical and emotional boundaries.
- Parents/caretakers are able to provide positive support to their child's efforts to cope with sexualized thoughts and feelings.

- Parents/caretakers are effectively using behavioral management strategies.
- The frequency of positive interactions between the parent/caretaker and the child has increased.

Developmentally Problematic: Planned, Coercive, Interpersonal Sexual Behavior

Client profile

This profile would account for children who engage in abusive sexual behaviors which were planned, involved coercion, and targeted other children. These behaviors often resemble those of adolescents who have engaged in abusive sexual behaviors. These children use verbal and/or physical coercion to gain victim compliance. Their sexual behaviors are usually "adult like" and intrusive. These children often have multiple victims and the frequency of these behaviors is elevated. Their victims tend to be younger or more vulnerable children with whom they have unsupervised contact (e.g., siblings). These children are frequently victims of abuse and maltreatment in multiple forms including exposure to family and/or community violence. They may have non-sexualized conduct problems (e.g., stealing, lying, and aggression). These children usually have poor social skills and struggle to develop and maintain same age friendships. They are often distrustful of adults and authority figures. These children often lack adequate supervision and structure. Their parents/caretakers usually have difficulty managing their behaviors and may resort to either permissive or punitive methods of discipline. Emotional and physical boundary violations are common in their family system. These children frequently have deviant, delinquent, or criminal behaviors modeled to them. The child's sexual behaviors cause harm and distress for their victim(s) and violate social norms.

Treatment Goals

- Establish safety in the child's home and social environment.
- Ensure compliance to a safety plan to ensure supervision during any contact with younger or more vulnerable children.
- Establish rules for sexual behaviors with the child and parents/caretakers.
- Provide needed age appropriate psycho-education (see previous categories for details).
- Address trauma symptoms related to the child's history of abuse/maltreatment using an evidence based trauma focused treatment model.
- Ensure the child is honest and accountable for their victim selection, use of coercion, and abusive sexual behaviors.
- Help the child internalize pro-social beliefs and attitudes.
- Enhance the child's ability to recognize others' emotional states and respond in a respectful manner.
- Older children will develop insight into the difficult feelings, unhelpful thinking and dangerous situations which lead to the inappropriate behaviors.
- Older children will complete a narrative regarding their inappropriate sexual behaviors.

- When appropriate, the child will make amends to anyone negatively impacted by their behaviors.
- Help the child develop and maintain healthy same age peer relationships and/or involvement in healthy social programs.
- Help the family establish physical and emotional boundaries.
- Help parents/caretakers effectively and appropriately respond to their child's sexual behaviors.
- Help parents/caretakers communicate prosocial and healthy beliefs regarding sexuality with their child/children.
- Assist parents in developing effective behavioral management techniques (see previous categories for details).
- Improve the parent-child relationship.

Treatment Providers:

Clinicians providing these services should be licensed mental health treatment providers with training in child development, experience working with children and families using evidence based trauma focused treatments, and experience providing NOJOS approved sex specific treatment. Therapists should also have experience working with family systems and providing effective behavioral management training. Therapists must also be capable of coordinating care with DCFS workers, the court system, and foster care providers. Any unlicensed mental health providers should maintain close supervision by a licensed mental health provider meeting the above criteria when working with this population.

Treatment Modalities and Frequency:

Many children in this profile will require an out-of-home placement (e.g., kinship, foster home, or residential placement) and DCFS involvement. Foster care programs should have adequate resources to support foster parents/care providers offering caring for these children. In a few cases, a residential placement may be needed to stabilize the child's behaviors and reduce the risk to the community. Treatment modalities should include individual, family, and group therapy. Therapy should occur on at least a weekly basis and more frequently in some cases. Day treatment services or a structured classroom placement is also often warranted. Other wrap around services may be needed including after school programing, respite, and social skill development. Typically treatment lasts a year or longer; however, completion of treatment should be contingent on the child's and/or family's internalization and application of concepts and skills developed in therapy.

Monitoring:

DCFS is typically involved in these cases and will be responsible for ensuring an appropriate placement is available and monitor for compliance to the safety plan and participation in therapy. If the child is placed in State's custody, the court will be involved in monitoring

progress and compliance to the service plan. Parents/caretakers are responsible for following the safety plan and reporting any safety or behavioral issues which emerge to the court, DCFS worker, and therapist. Staff from other agencies (e.g., foster care program, school placement, respite providers) which are providing wrap around services are also responsible for ensuring adequate supervision and structure while the youth is in their care and reporting any problems or concerns.

Criteria for Discharge:

- The child is complying with the sexual behavior rules.
- The child and family are complying with a formal safety/prevention plan independent of external systems.
- The child and family are using social support systems and community resources necessary to maintain safety and provide structure and stability.
- The child is fully accountable for his/her abusive behaviors (including his/her use of coercion).
- The child has completed a formal narrative regarding their own trauma history and sexual behavior problems without using cognitive distortions or experiencing undue distress.
- The child has made amends regarding their abusive behaviors when appropriate.
- The child is able to behave in a manner that is respectful of other's emotions.
- The child is effectively using self-regulation and self-control skills to manage his/her behaviors.
- The child has developed and maintained age appropriate friendships and/or is successfully engaging in healthy social outlets.
- Older children have demonstrated increased insight into his/her own internal processes by using effective coping skills for difficult feelings, altering cognitive distortions, and coping with dangerous situations.
- When appropriate, the child and family have successfully completed reunification services.
- The family has adopted prosocial attitudes and behaviors.
- The family system is maintaining healthy and appropriate physical and emotional boundaries.
- Parents/caretakers are able to provide positive support to their child's emotional and social needs.
- Parents/caretakers are effectively using behavioral management strategies.
- The frequency of positive interactions between the parent/caretaker and the child has increased.

Education and Placement Guide for Schools

Introduction:

In treating youth who have engaged in sexually abusive behavior or misconduct, finding a balance between risk management, community safety, educational and normative developmental needs is a difficult task. When a young person is known to have engaged in sexually abusive behavior this poses a unique situation for school district personnel, as they are charged with providing every student with an education, as well as for providing for the safety of every student; however, current research and literature supports that these youth can succeed and even excel in mainstream public school and often greatly benefit from these normative experiences.

While considering this, it is critical to also be cognizant of factors of importance to the school personnel when placing youth in a public school setting. These include:

1. What was the age of the identified victim(s)?
2. Is the victim from/at the school the youth is to attend/attending?
3. Based on what is needed, what is the plan for assessed needed supervision that should be included in the safety plan (adult supervision, line of site, normative supervision within the school setting, etc.)?
4. Does the student who engaged in sexual misconduct have his/her own victimization history?
5. Does the student have any special education needs?
6. Where did the offense(s) occur (community, home, school, etc.)?
7. What is the prescribed treatment, as well as what is the NOJOS placement level?

Purpose:

The purpose of the Education and Placement Guide for Schools is to provide information to assist school personnel, sex-offense specific treatment providers, and other informed supervisors of the responsibilities of providing a safe community and an inclusive environment while accounting for the risk to and educational needs of all students (Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behavior, 2003).

This guide highlights the need for a multidisciplinary team to work with each youth on an individual basis that is geared toward finding the balance between risk management and appropriate educational placement, based on accurate juvenile risk assessment, supervision and treatment. It will be important for a school system receiving a student to have a plan in place regarding which personnel needs to know information related to the youth's sexual misconduct, and that this information is shared **only** on a need-to-know basis.

In **all** situations, the legal guardian for the youth in question should sign a release of information prior to any information being shared between parties.

Following these guidelines promotes community safety, the individual educational needs of the youth, and awareness of a youth's developmental needs in making school placement decisions.

Guiding Philosophy:

The primary focus in treating juveniles who have engaged in sexually abusive behavior has been to promote "no more victims. Current literature and best practice standards support the notion that understanding and treating a youth's individual holistic treatment needs will more effectively promote change and healing (Prescott, David S. and Longo, Robert E., Current Perspectives: Working with Sexually Aggressive Youth and Youth with Sexual Behavior Problems, NEARI Press, 2006) and, accordingly, enhance community safety. Therefore, it is imperative that a working multidisciplinary team be developed to effectively manage, treat, and supervise these youth while still providing for their educational needs. This team should be comprised of, but not be limited to, a school district representative, school administrator, teacher, sex-offense specific clinician, adult supervisor(s) and case manager and/or probation officer.

An appropriate school setting in which educational and developmental needs are met is an important part of providing effective treatment as well as appropriate education to juveniles who have engaged in sexually abusive behavior. In order to provide a balance between the appropriate treatment and educational settings, a thorough assessment of a youth's current level of risk for sexual re-offense is necessary. An appropriate assessment of risk can be obtained by completing a sexual behavior risk assessment, psychosexual. The assessment should include recommendations about educational settings.

Additionally, a juvenile's educational and treatment needs will likely change over the course of his/her education and treatment. These changes should be communicated within the treatment team, having all the appropriate releases of information in place to do so.

Goals:

One of the priorities in the treatment of youth who have engaged in sexually abusive behavior is providing for community safety. Balancing the needs of the youth and community can be difficult, but it is an imperative task that requires a collaborative approach. In order to balance the needs of victims, community safety, and the individual juvenile there must be an educated, coordinated, and collaborative multidisciplinary team effort. In order to aide in this process, the following goals have been identified in the Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behavior, 2003;

1. Enhancing victim protection and reducing potential for further victimization of other students through increased supervision and awareness of offenders' risk factors;
2. Promoting a safer educational environment, inclusive of juveniles who engaged in sexually abusive behavior through participation in a multidisciplinary team;
3. Improving the exchange of information between systems of care so that seamless interaction occurs among all relevant private and public agencies and the school district;

4. Enhancing the monitoring and supervision of juveniles to whom the NOJOS Protocols and Standards Manual apply;
5. Providing safer school environments by monitoring the student's stability within the school (Increased monitoring assists in the assessment of risk factors, the student's compliance with treatment goals, and evaluation of appropriate placement options);
6. Providing educational opportunities for school personnel to understand the continuum and dynamics of sexually abusive behavior and victim safety; and
7. Providing for normal educational experiences through a school setting, including extra-curricular activities, when safety of other students can be assured.

Procedure:

Placement decisions are the most important decisions in balancing the juvenile's risk to re-offend (community protection/abuse prevention) and the need to help the juvenile develop in a manner that increases the likelihood of a positive adult lifestyle. Youth should be placed in the *least-restrictive environment* necessary to reduce/minimize risk and provide adequate treatment to facilitate positive growth. Risk-management practices must match the risk level of the juvenile. According to national standards, treatment is most effective when the intensity of services match the youth's risk of recidivism.

The associated risk assessment should specify the specific needed services that will allow the student to be successful at school while still promoting community safety. This should be included for all levels of care across the continuum.

Level One: Outpatient Psycho-sexual Education

If the behavior has occurred in a school setting, continued placement in a public school setting is appropriate ensuring any concerns for the identified victim are addressed. If the identified sexual misconduct occurred at school, a school administrator should be involved in developing an appropriate safety plan to monitor the youth's behavior. The juvenile and his/her parent(s) should also be involved in the development of this plan. Additionally, a copy of a "certificate of completion" from the Level One treatment provider may also be submitted to the school administrator (if required) by the youth or his/her parent(s) for verification that the~~y~~ youth has complied with and completed the Level One treatment course.

Level Two: In-Home/ Outpatient Sex-Offense Specific Psychotherapy

If the behavior occurred in the school setting the youth is currently attending, a school administrator should be involved in developing an appropriate safety plan to monitor the youth's behavior and treatment progress. The parent(s) and the youth should be involved in the development of this safety plan. In these circumstances, the school administrator should be updated periodically as to the progress the youth is making in his treatment and his overall compliance with the developed safety plan. Additionally, safety should also be taken into consideration in regards to preventing the potential for retaliation by peers attending the school.

If the behavior did not occur in a school setting school personnel should be notified if clinically necessary and the appropriate releases signed.

It is the responsibility of the parent or legal guardian to comply with any safety plan issues identified by the risk assessment and/or treatment provider, although the school may help facilitate the implementation of this.

If the identified victim(s) also attends the same school, specific care should be taken to assess the appropriateness of having the juvenile and identified victim(s) in the same school together. Specific attention to the perceived safety by the victim(s) should be given. Additionally, there may often be a "no contact" order in place. In these situations, it may be necessary, as feasible, for a change in school placement to occur within the community and in accordance with the educational needs of those involved. If a change is deemed necessary and resources are available, it is preferable the identified youth who engaged in the sexual misconduct change schools.

Continued placement in a public school setting is appropriate.

Level Three: (A) Sex-Offense Specific Day Treatment or (B) Intensive in-home/Outpatient Services

Definition:

A "day-treatment" setting may provide for a student's education needs in a non-traditional school placement that is licensed by the State of Utah as a day treatment facility. In this type of facility, the education needs of the students are met in a setting that **is not** the student's home school or the local neighborhood school.

Type A: For youth placed in a day treatment setting, developing a public school safety plan is not immediately necessary, but strongly recommended upon transition back into the public school setting. The day treatment provider should strongly consider developing a safety plan for placement in this setting. This process will require close communication between the NOJOS Level Three treatment provider, the parent(s) and school district representative and/or school administrator as to when placement back into the public school setting is warranted, based on addressing the issues requiring placement in a day treatment setting.

A Level Three placement may also be made for Level Four or Level Five youth who are appropriate for attending school in a public school setting, but present with social, behavioral, or learning difficulties/disabilities that cannot be adequately managed in a traditional school setting.

When a day treatment placement is being requested, the Level Four or Five treating clinician should submit in writing to the school district representative (i.e., Youth in Custody Coordinator) an abbreviated summary of the completed risk assessment including a description of the charges, an overview of the offense(s), the associated risk, and recommended level of

treatment. An example of the "school placement risk assessment" can be found at the end of this document.

The intention of the treatment provider to have a youth enrolled in a public school setting should be made known by requesting a "school intake" meeting. At this meeting, the case should be staffed with the school district representative, treatment provider, and case manager. A school administrator and the assigned clinician may also be invited to attend as needed. A plan to transition the youth back into a mainstream public school setting should be made and be contingent upon the successful completion of the assigned Sex-Specific Day Treatment program. A copy of a "certificate of completion" should be provided to the school district representative prior to placement back into a mainstream public school setting.

Type B: NOJOS Level Three treatment may also include youth who are participating in outpatient sex-specific treatment along with intensive in-home services. For youth participating in this treatment option, placement in a public school setting is appropriate, and the protocol for NOJOS Level Two youth should be followed.

Level Four: Community-Based Structured Foster Care

These youth usually present as a **moderate risk** for sexual re-offense as assessed by nationally recognized risk assessment tools. Placement in the public school or day treatment setting is appropriate for this level of care and should be considered on a case-by-case basis based on the youth's presenting problems and risk assessment.

When a youth is placed in a Level Four placement the treating clinician should submit in writing to the school district representative (i.e. Youth in Custody Coordinator or the like) an abbreviated summary of the completed risk assessment including a description of the charges, an overview of the offense(s), the associated risk level assessed in the given risk assessment, and recommended level of treatment. An example of the "school placement risk assessment summary" can be found at the end of this document. The intention of the treatment provider to have the youth enrolled in a public school should be noted. A "school intake" meeting should be scheduled. At this meeting the case should be staffed with the school district representative, treatment provider, and case manager. A school administrator and the assigned clinician may also be invited to attend as needed. The school letter should note that the juvenile "is appropriate for standard Youth in Custody supervision" or the determined appropriate amount of supervision needed. Additionally, a statement affirming any additional supervision needs required will be provided by the treatment provider should be included. An example of these statements can be found in the sample school letter at the end of this document.

It can be expected that upon placement in a public school setting a youth may have all or nearly all of his/her classes in a contained classroom or Youth in Custody classroom setting, based on the prescribed NOJOS treatment needs and district personnel discretion. **A student's special education needs, however, will need to be considered in all placement decisions, including when placing a student into a self-contained classroom setting.**

Upon assessment by the teacher(s), school administrator as necessary, school district representative, treatment provider, and treating clinician a youth may be allowed to have one or more mainstream classes. This will be assessed by the multidisciplinary team on a case-by-case basis.

Level Five: Community-Based Group Home/ Independent Living

Level Five youth fall into two categories; 1) Sex-Specific Group Home and, 2) Independent These youth usually present as a **moderate risk** for sexual re-offense as assessed by nationally recognized risk assessment tools. Placement in a public school or day treatment setting is appropriate for this level of care and should be considered on a case- by-case basis based on the youth's presenting problems and risk assessment.

When a youth is placed in a Level Five placement the treating clinician should submit in writing to the school district representative (i.e. Youth in Custody Coordinator or the like) an abbreviated summary of the completed risk assessment including a description of the charges, an overview of the offense(s), the associated risk level assessed in the given risk assessment, and recommended level of treatment. An example of the "school placement risk assessment" can be found at the end of this section. The intention of the treatment provider to have the youth enrolled in a public school should be noted. A "school intake" meeting should be scheduled. At this meeting the case should be staffed with the school district representative, treatment provider, and case manager. A school administrator and the assigned clinician may also be invited to attend as needed. The school letter should note that the juvenile "is appropriate for standard Youth in Custody supervision" or the determined appropriate amount of supervision needed. Additionally, a statement affirming any additional supervision needs required will be provided by the treatment provider should be included.

It can be expected that upon placement in a public school setting that a youth may have all or nearly all of his/her classes in a contained classroom or Youth in Custody classroom setting based on the prescribed NOJOS treatment needs and district personnel discretion. **A student's special education needs, however, will need to be considered in all placement decisions, including when placing a student into a self-contained classroom setting.**

Upon assessment by the teacher(s), school administrator as necessary, school district representative, treatment provider, and treating clinician, a youth may be allowed to have one or more mainstream classes. This will be assessed by the multidisciplinary team on a case-by-case basis.

Level Six: Sex-Offense Specific Residential Group Home

Level six youth present with a much higher risk to engage in sexual misconduct and are often sexually preoccupied. These youth have serious and significant sexual acting-out issues. Due to their increased risk these youth require intervention in a structured and restrictive residential treatment setting. These youth's risk score in the **moderate-to-high and high risk** for sexual re-offense and therefore cannot remain in the community. Accordingly, a Level Six placement

will provide its own self-contained school setting where these youths' educational needs can be met while providing the supervision and intensity of treatment they require.

In some instances, however, a treatment provider may determine a youth to be appropriate to be transitioned into a public school setting after having made significant strides in his/her sex-offense specific treatment as well as having reduced his/her assessed risk. Prior to making such a recommendation for transition into a public school setting a thorough sexual behavior risk assessment using nationally recognized risk assessment tools should be completed by a NOJOS Certified Clinician, and the case should be staffed with the appropriate school district personnel.

If the results of given risk assessment verify that the youth's risk level has reduced and the student is appropriate for a public school setting, the Level Six treating clinician should submit in writing to the school district representative (i.e. Youth in Custody Coordinator or the like) an abbreviated summary of the completed risk assessment including a description of the charges, an overview of the offense(s), the associated risk level assessed in the risk assessment, and recommended level of treatment. The intention of the treatment provider to have the youth enrolled in a public school should be noted. A "school intake" meeting should be scheduled. At this meeting the case should be staffed with the school district representative, treatment provider, and case manager. A school administrator and the assigned clinician may also be invited to attend as needed. The school letter should note that the juvenile "is appropriate for standard Youth in Custody supervision" or the determined appropriate amount of supervision needed. Additionally, a statement affirming any additional supervision needs required will be provided by the treatment provider should be included. .

It can be expected that upon placement in a public school setting that a youth may have all or nearly all of his/her classes in a contained classroom or Youth in Custody classroom setting. Upon assessment by the teacher(s), school administrator as necessary, school district representative, treatment provider, and treating clinician, a youth may be allowed to have one or more mainstream classes. This will be assessed by the multidisciplinary team on a case-by-case basis.

Level Seven: Inpatient Psychiatric/ Sex-Specific Treatment

Youth appropriate for Level Seven present with an acute or chronic psychiatric disturbance, are sexually impulsive, display unpredictable/uncharacteristic or pattern of bizarre/ritualistic offenses, unpredictable social behaviors and present a **high risk** to the community and/or safety of other youth in lower level programming. Due to these youth's risk level, placement in a public school setting is inappropriate and the treatment provider will provide its' own self-contained educational setting so as to meet the individual education needs of each youth.

These youth, when appropriate, will be stepped down to a lower level of care once the acute nature of their behaviors and/or psychiatric disturbance, as well as associated risk level, has been reduced. At the time of discharge, care should be taken by all team members to specifically discuss the youth's education needs and in what type a setting these can be most effectively met. Typically, this placement will be to a NOJOS Level Five or Four community-based treatment setting with placement in a public school setting. However, the addition of

having the youth enroll in a NOJOS Level Three program in conjunction with the community-based group home/foster home placement should also be considered.

Any placement into the public school system will necessitate a similar communication and enrollment process outlined in Levels Four, Five, and Six.

Level Eight: Secure Care/ Correctional Treatment Enhanced

Level Eight youth have displayed repetitious, predatory, fixated and /or violent patterns of offending. Level Eight youth may also display other criminality or non-sexual aggression that makes them too risky to be allowed to reside in a community placement. These youth present an **extreme risk** to the community. Due to the risk level of these youth, Level Eight programs provide their own contained educational settings to meet the educational needs of their clients.

When a youth who has completed his/her sentencing guidelines and are being considered for release to a less restrictive treatment setting (Level Six, Five, Four, or Two), a treatment team meeting should occur to discuss at what level the youth's current treatment needs and associated risk can best be managed.

Any placement into the public school system will necessitate a similar communication and enrollment process outlined in Levels Four, Five, and Six

Placement Letter

School Placement Risk Assessment Summary

*****Please use discretion in the release of the juvenile's private/sensitive information and restrict to only those persons named in the release by the guardian so as to avoid inclusion into the school record. This information is released by school personnel on a need-to-know basis. (School District Administrator, School Administrator Personnel, School Psychologist).

Date

[Youth In Custody Coordinator]
YESS Program Coordinator
2500 S. State St.
SLC, UT

Somewhere Junior High School staff
Someplace City, UT

[YIC Coordinator]

[Juvenile] has been referred to our NOJOS Level Five community-based group home by his DCFS caseworker, [Case manager]. [Youth] was placed in the [facility name] group home on (date) and is expected to attend Somewhere Junior High School. Prior to this referral [youth] was residing with his/her biological parents. [Youth] was referred to this placement following several incidents of sexually touching younger neighborhood children and his younger sister. [Youth] was placed in a structured community group home setting due to his sibling victim and ongoing behavioral problems. Following his/her initial placement into the custody of [DHS, DCFS, DJJS], [youth] participated in a Sex Behavior and Risk Assessment which made the recommendation for a "NOJOS Level Five community based group home setting."

The results of [youth's] risk assessment identified several risk factors and rated his overall sexual re-offense risk level as "moderate" and as "high" risk for further non-sexual delinquent behavior. Specific risk factors identified included his minimizing his offenses, poor acceptance of responsibility, use of cognitive distortions, increased interpersonal aggression, and conflicts with authority. [Youth] is being taught how to have healthy sexual attitudes, take responsibility for his behaviors, engage in appropriate interpersonal boundaries, respond to social cues, be sensitive to others, develop victim empathy, intervene regarding risk factors, and develop healthy coping skills. As part of his risk assessment [youth] was administered the Juvenile Sex

Offender Assessment Protocol (J-SOAP II), Juvenile Sexual Offense Recidivism Risk Assessment Tool (JSORRAT-II) and the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR).

Again, based on the results of his risk assessment it was recommended that [youth] be referred to a NOJOS Level Five community based group home setting due to his ongoing behavioral problems and having a victim present in his home. This type of placement setting is commensurate with being placed in a community setting and attending public school.

Based on [youth's] identified risk and treatment needs, the [agency] will provide [youth] with behavioral modification and individual and group sex offense-specific treatment. Accordingly, [youth's] current educational needs can be met with the standard YESS Program supervision which he has been receiving. The communication of any behavioral observations as well as academic needs would benefit [youth's] current treatment and would be greatly appreciated.

Additionally, the [agency] is able to provide any additional supervision needs in one of three ways; 1) attend school with the youth during a specific period of the academic day or all day, 2) have the youth remain home from school, or 3) remove the child permanently from the YESS Program and place him in an alternative school setting.

Furthermore, [youth's] individual therapist and/or Group Home Supervisor will be in contact with his identified school therapist and/or teacher to update any other identified risk factors and how the [agency] is managing these.

Thank you for your time and effort on behalf on [youth's] educational needs. Please feel free to contact me directly at [phone number] with any questions or concerns.

Sincerely,

[NOJOS Certified Clinician/ Affiliate Provider]

References and Resources

Amand, A. St., Bard, D. E. & Silovsky, J. F. (2008). *Meta-Analysis of Treatment for Child Sexual Behavior Problems: Practice Elements and Outcomes*. Child Maltreatment, 13, 145-166.

American Polygraph Association (2012). Model Policy for the Evaluation of Examinee Suitability for Polygraph Testing. [Electronic version] Retrieved DATE, from http://www.polygraph.org.

Association for the Treatment of Sexual Abuses (2011). *Children with Sexual Behavior Problems.* http://www.atsa.com/children-sexual-behavior-problems.

Baranowsky, A., Gentry, J. E., & Schulta, D. R. (2005). Trauma Practice: Tools for Stabilization and Recovery. Cambridge, MA: Hogrefe and Huber.

Barbaree, H. and Marshall, W., Editors, The Juvenile Sex Offender, Second Edition, The Guilford Press, 2006

Bonta, J. and Andreas R. The Psychology of Criminal Conduct, 6th Edition, Routledge, 2016.

Burton, J., Rasmussen, L. A., Christopherson, B. J., Bradshaw, J., & Huke, S. C. (In Press). Interrupting Sexually Abusive Behavior Problems: A Clinician's Guide for Child and Parent *Treatment*. Newbury Park, CA: Sage Publications.

Carpentier, M.Y., Silovsky, J. F. & Chaffin, M. (2006*). Randomized Trial of Treatment for Children with Sexual Behavior pPoblems: Ten-Year Follow-up*. Journal of Consulting and Clinical Psychology, 74, 482-488.

Coffey, Patricia, Ph.D., *Forensic Issues In Evaluating Juvenile Sex Offenders*, Risk Assessment of Youth Who Have Sexually Abused, Prescott, David S., LICSW, Wood & Barnes Publishing, 2006, page 80-81.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York: NY. Guilford Press.

Colorado Department of Public Safety (Division of Criminal Justice, Colorado Sex Offender Management Board & Colorado Department of Education, Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behavior, December 2003.

Creeden, K., *Integrating trauma and attachment research into the treatment of sexually abusive youth*. In M.C. Calder (Ed.), Children and Young People Who Sexually Abuse: New Theory, Research, and Practice Developments. Lyme Regis, Dorset: Russell House Publishing, 2004.

Creeden, K., *Trauma, Attachment and Neurodevelopment: Implications for Treating Sexual Behavior Problems*. In B. Schwartz (Ed.), The Sexual Offender, Volume V. Kingston, NJ: Civic Research Institute, 2005.

Creeden, K. (2005). *Trauma and neurobiology: Considerations for the treatment of sexual behavior problems in children and adolescents.* In R. Longo & D. Prescott (Eds.) Current Perspectives: Working With Sexually Aggressive Youth and Youth With Sexual Behavior Problems. Holyoke, MA: NEARI Press.

Friedrich, W. (1997). Child sexual behavior inventory Professional manual. Odessa, Florida: Psychological Assessment Resources, Inc.

Friedrich, W.N., Fisher, J., Broughton, D., Houston, M., Shafran, C. (1998) *Normative sexual behavior in children: A contemporary sample*, Pediatrics, 101, (4), 1-8.
Friedrich, W. (2007). Children with sexual behavior problems: family based attachment focused therapy. New York, NY: Norton & Company.

Hall, D. K., Mathews, F., & Pearce, J. (2002). Sexual behavior problems in sexually abused children: A preliminary typology. Child Abuse and Neglect, 26, 299-312.

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The Principles of Effective Correctional Treatment Also Apply to Sexual Offenders: A Meta-Analysis. Criminal Justice and Behavior, 36 865-891

Johnson, T. C. (2003). *Child sexual behavior checklist-Revised*. In assessment packet for children with sexual behavior problems. South Pasadena. CA: Author. www.tcavjohn.com.

Johnson, T. C., & Doonan, R. (2006). *Children Twelve and Younger with Sexual Behavior Problems: What We Know in 2005 That We Didn't Know in 1985*. In Longo, R. E. & Prescott, D. S. (Eds.) Current perspective: working with sexually aggressive youth & youth with sexual behavior problems (pp. 79-118). Holyoke, MA: NEARI Press.

Johnson, T. C. (2015). Understanding Children's Sexual Behaviors; What's Natural and Healthy. South Pasadena, California.

Johnson, T. C. & Doonan, R. (2006). *Children Twelve and Younger with Sexual Behavior problems: What We Know in 2005 That We Didn't Know in 1985*. In Longo, R. E. and Prescott. D. (Eds.) Current Perspectives: Working with Sexually Aggressive Youth and Youth with Sexual Behavior Problems (pp. 79-118). Holyoak, MA: NEARI Press

Kinniburgh, K., Blausteink, M. & Spinazzola, J. (2005). *Attachment, Self-Regulation and Competency*. Psychiatric Annals, 35 (5), 424-430

Kluckhohn, C., & Murray, H. A. (1953). Personality in Nature, Society, and Culture *(2nd ed.).*

New York: Alfred Knopf.

Latham, C. & Kinscherff, R. (2012*). A Developmental Perspective on the Meaning of Problematic Sexual Behavior in Children and Adolescents*. Holyoak, MA: NEARI Press.

Lew, M. . Victims No Longer, Quill, 2004.

Longo, R. E. & Prescott, D. (2006). Current Perspectives: Working With Sexually Aggressive Youth and Youth With Sexual Behavior Problems. Holyoak, MA: NEARI Press.

Medoff, D., & Kinscherff, R. (2006). *Forensic Evaluation of Juvenile Sexual offenders*. In S. N. Sparta & G. P. Koocher (Eds.). Forensic Mental Health Assessment of Children and Adolescents (pp. 342 – 364). New York: Oxford University Press.

McNeil, C. B. & Hembree-Kigin, T. L. (2010). Parent-child Interaction Therapy. New York, NY: Springer.

National Task Force on Juvenile Sexual Offending (1993). *The revised report from the National Task Force on Juvenile Sexual Offending of the National Adolescent Perpetrator Network*. Juvenile & Family Court Journal, 44 (4), 1-120.

Prentky, R. A., Righthand, S., & Lamade, R. (2016). *Sexual Offending: Assessment and Intervention*. In Heilbrun, K., DeMatteo, D., & Goldstein, N. E. S. APA Handbook of Psychology and Juvenile Justice. Washington, DC: American Psychological Association

Prescott, David S., and Longo, Robert E., *Current Perspectives: Working with Young People Who Sexually Abuse*, Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E and Prescott, David S., Editors, NEARI Press, 2006, page 53-54.

Prescott, D. (2006). Risk Assessment of Youth Who have Sexually Abused: Theory, Controversy, and Emerging Strategies. Oklahoma City, OK: Woods and Barnes Publishing.

Rasmussen, L. A., Burton, J., & Christopherson, B. J. (1992). *Precursors to Offending and the Trauma Outcome Process in Sexually Reactive Children*; Journal of Child Sexual Abuse, 1(1),
33-48.

Rich, P. (2012). Introduction. In Latham, C. & Kinscherff, R. A Developmental Perspective on the Meaning of Problematic Sexual Behavior in Children and Adolescents. Holyoak, MA: NEARI Press.

Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide to Risk Evaluation. Hoboken, New Jersey: John Wiley & Sons Inc.

Rich, P., Understanding, Assessing, and Rehabilitating Juvenile Sexual Offenders, John

Wiley & Sons, Ltd., 2003

Rich, P., Attachment and Sexual Offending: Understanding and Applying Attachment Theory to the Treatment of Juvenile Sexual Offenders, John Wiley & Sons, Ltd., 2006

Ryan, G. and Lane, S., *Juvenile Sexual Offending Causes and Consequences*. New and Revised Edition, Jossey-Bass A Wiley Company, 1997

Utah Legislative website. *Utah State Code 78A-6-102 Annotated Establishment of Juvenile Court -- Organization andsSatus of Court – Purpose*. http://le.utah.gov/code/TITLE78A/htm/78A06_010200.htm

Ward, T., Polaschek, D., and Beech, A., Theories of Sexual Offending, John Wiley & Sons, Ltd., 2006

Worling, J.R., & Curwen, T. (2001). Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0. Toronto, Ontario, Canada: Ontario Ministry of Community and Social Services.

.Psychosexual Education Resources

Burton, Jan Ellen, PhD, Rasmussen, Lucinda, A., PhD, Bradshaw, Julie, LCSW, Christopherson, LCSW, & Huke, Steven C., MS. Treating Children with Sexually Abusive Behavior Problems: Guidelines for Child and Parent Intervention.

Books for Adolescents on Human Sexuality

Brown, L., & Brown, M. (2000). What's the Big Secret?: Talking about Sex with Girls and Boys, Reprint Ed. Little, Brown Young Readers.

Cole, Joanna. (1988). Asking About Sex and Growing Up. William Morrow & Co., Inc.

Gordon, S. & Cohen, V. (1992). Facts About Sex for Today's Youth, updated edition. Prometheus Books.

Gordon.S. (2001). How Can You Tell If You're Really In Love? Adams Media Corporation.

Gordon.S. (1990). Why Sex is Not Enough, Revised Ed. Adams Media Corporation. Gordon, S. & Gordon, J. .

Gordon, S., Gordon, J., & Cohen, V. (1992). A Better Safe Than Sorry Book: A Family Guide for Sexual Assault Prevention. Prometheus Books.

Harris, R.H. (2000). It's So Amazing! A Book about Eggs, Sperm, Birth, Babies, and Families. The Horn Book Magazine.

Harris, R. H., & Emberley, M. (2004). It's Perfectly Normal: Changing Bodies, Sex and Sexual Health, 10th Anniversary Ed. Candlewick Press.

Joannides, P. (2001). Guide to Getting It On, New Ed. Vermillion. www.goofyfootpress.com.main.

Madaras, L. (2000). My Body, Myself for Girls. New York: New Market Press. Madaras, L. (2000). *My Body, Myself for Boys*. New York: New Market Press.

Madaras, L. (2000) My Feelings, My Self. News York: New Market Press.

Peter, V. & Dowd, T. (2000). Boundaries: A Guide For Teens. Boys Town, Nebraska: Boys Town Press.

Books for Youth on Sexuality (8 – 12 years old)

Madaras, L. (1993). The "What's Happening To My Body?" Book for Girls. New York: Newmarket Press.

Madaras, L. (1993) *The "What's Happening To My Body?" Book for Boys.* New York: Newmarket Press.

Books for Youth on Sexuality (3 – 8 years old)

Brown, L. K. & Brown, M. (1997). What's the Big Secret? Talking About Sex With Girls and Boys. New York: Little Brown.

Cole, J. (1993) How Were You Born? New Jersey: Wilmore, Inc.

Adolescent Treatment / Placement Protocol

Gordon, S. & Gordon, J. (1990) Did the Sun Shine Before You Were Born*?* New York: Prometheus Books.

Meredith, S. (1991). Where Do Babies Come From? Usborne, OK: Starting Point Science.

Nelson, L. (1993) How Was I Born? New York: Dell Trade.

Schoen, M. (1990) Belly Buttons Are Navels. New York: Prometheus Books.

Books for Parents on Sexuality

Gordon, S. & Gordon, J. (1999). Raising a Child Responsibly in a Sexually Permissive World, 2nd Ed. Adams Media Corporation.

Websites

Perry, Bruce. www.childtraumaacademy.com/surviving_childhood/index.html.
Free on-line courses offered by the Child Trauma Academy on topics such as "Bonding and Attachment in Maltreated Children" and "Surviving Childhood: An Introduction to the Impact of Trauma". CEU's available for practitioners in Texas and California.

www.childtrauma.org/ctamaterials/Professions/asp
Childhood trauma topics.

www.neari.com
Various publications.

www.kids-in-mind.com/
Film reviews regarding sexual content, violence, language, etc.

www.healthteacher.com/ Sexuality for youth.

www.guttmacher.org/pubs/fb_sex_ed02.pdf National Council on Juvenile and Family Court Judges. (Note: an underline "_" appears before an after "sex".)

www.guttmacher.org/pubs/fb_teens.pdf National Council on Juvenile and Family Court Judges. (Note: an underline "_" appears before "teens".)

www.socio.com/srch/summary/pasha/paspp03.htm
Search Institute

www.tlcinst.org
National Trauma and Loss Institute

http://www.darkness2light.org
From Darkness To Light: Darkness to Light is a non-profit organization dedicated to the primary prevention of child sexual abuse.

DVDs/Videos

General Themes

"Offenders and Survivors Speak Out On Sexual Abuse" DVD, www.speakoutvideo.com.

"Why God, Why Me?" Video focused on victim empathy.

" Drug Called Pornography." Video about pornography and how it can be addicting.

"Things Behind the Sun." Video depicts an adult who was raped as a teenager and who abuses alcohol and engages in risky sexual behavior as an adult.

"He Got Game" Rated R

"The Good Son" Rated R

"Imaginary Heroes" Rated R

"End of the Spear" Rated PG-13

"Hotel Rwanda." Domestic strife, survival, war. Rated PG-13

"Coach Carter." Therapeutic theme, cultural values, family issues, etc. Rated PG-13

Family Abuse Themes

"Nuts" Rated R Incest dynamics, victim impact

"Bastard Out of Carolina." Rated R. Video depicts the sexual abuse of a young girl by a stepfather, various family members reactions, and the effects on the family. (It was recommended that a juvenile have at least 9 months of therapy before viewing this film because of the level of sexual arousal to children elicited by this film.)

"Antwone Fisher." Video involving abuse. Rated PG-13

"Domestic Disturbance" Rated PG-1. Video involving violence, brief sexuality, language.

"Good Will Hunting"

"Once Were Warriors" Rated R. Pervasive language and strong depiction of domestic abuse, including sexual violence and substance abuse.

"Rabbit Proof Fence" Rated PG. Emotional thematic material.

Family Themes

"Ahkjeelah and the Bee" Rated PG. Video depicts family struggles, single parent.

"Dead Poets Society" Rated PG.

"House of D" Rated PG-13.

"Fathers and Sons" Rated R

"Whale Rider" Rated PG-13

"Radio" Rated PG

"I Am Sam" Rated PG-13