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.

<u>Qualifications of a Licensed Professional to Provide Assessment</u>

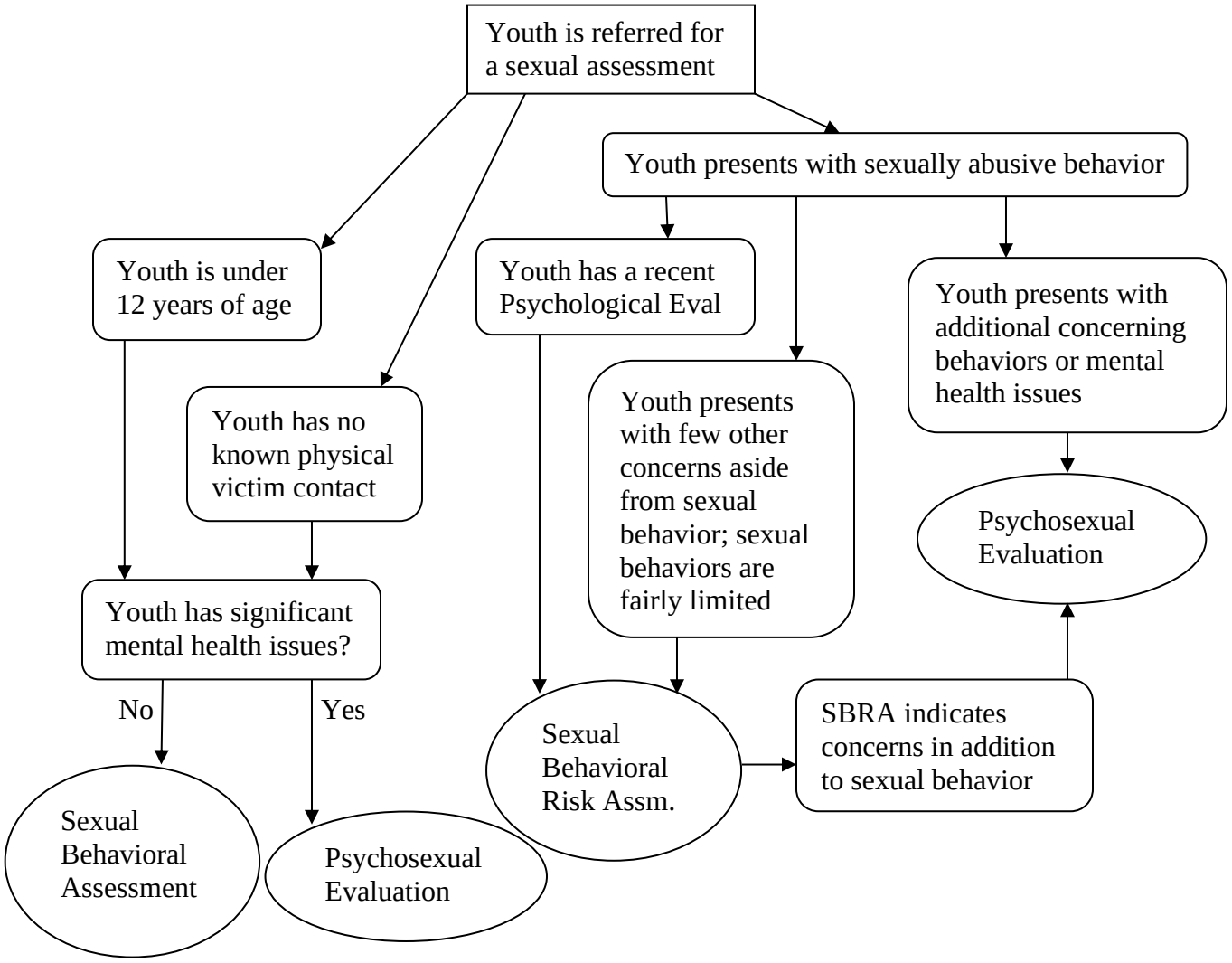
At a minimum, to qualify as an adolescent sex-specific therapist or evaluator the clinician needs to have sex-specific experience, expertise, and training in the following specialized skills: (1) adolescent development involving expected and normative attitudes, emotions, experiences, interactions, and 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.

<u>Recommendations Guideline</u>

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

<u>Overriding Principle Regarding Placement/Treatment Decisions with Juvenile Sexual Offenders</u>

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.