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

Client Profile

Level Six youth are *higher-risk* adolescents who engage in a broad range of sexually abusive behaviors and who are often hypersexualized and/or 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 indiscriminate arousal and a propensity to act out with same-aged peers in addition to their younger victims. 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 psychiatric setting). These youth often present with multiple vulnerabilities and deficits in their ability to meet their perceived needs in healthy ways. In addition, these youth often have additional comorbid mental-health issues and learning disabilities, and many also have a prior treatment history and/or legal involvement.

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. Comorbidity 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:
    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 functioning 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 neurotypicals but there should be adaptation and awareness of their individual needs. Providing social safeguards and staff awareness in these cases is important.

8. **History of childhood maltreatment and trauma**—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.

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—these are the 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 engage in sexually abusive behavior 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 24-hour 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.

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. Often academic needs will be met within the confines of the place 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 setting. This should be based on the needs and abilities of the school and the student to support a safe and structured transition.

Factors that DIFFER from a Level Five youth include:

1. Level Six youth 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.

See also: Factors associated with the onset, continuation, and cessation of abusive sexual behavior and nonsexual offending among male and female adolescent populations chart in Level Five above.)

Some of 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 strongly recommended.

Treatment and Supervision

Level Six treatment must include targeted sex-specific therapy including individual therapy, group therapy and family therapy weekly to provide the youth with information regarding healthy sexual functioning and prevent further development of their sexual misconduct while increasing healthy living skills. Treatment modalities include sex- specific treatment services (individual therapy, group therapy and family therapy) as well as psychosexual education and competency training groups in daily living and social skills training.

Sex-specific treatment goals for this Level should directly address the offending youth's individual needs based on their sexual risk and adaptive levels of functioning behaviorally, emotionally, socially, cognitively, and psychologically. Additionally, 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.

Level Six programs are 24-hour supervised, intensive community-based residential treatment program. It provides maximum, non-secure supervision, and intensive clinical intervention. It is a staff secure placement not a locked facility. 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, Good Lives Model).

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.

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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 coping strategies and competency skills, develop a family safety plan, develop healthy sexual attitudes and boundaries and develop and sustain understanding of victim injury and display 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.

Additional Considerations for Treatment

When it is assessed that a youth's sexually abusive behavior was influenced in some manner by pornography, treatment should include a balanced, rational, and individualized approach to address pornography use, in the same manner that other risk factors would be addressed. Treatment should help youth assess whether images and practices shown in pornography are realistic reflections of sexual relationships, consensual, or behaviors desirable to, and respectful of, sexual partners, and characteristic of physically and psychologically healthy social or sexual relationships (Bridges et al., 2010). Psychoeducation and treatment can help adolescents think critically about pornography and develop understanding of the potential unhealthy aspects of their pornography use, healthy aspects of future pornography use, positive and healthy sexual practices, relational aspects, and boundaries of sexual behaviors, and ensuring that sexual health and the qualities of healthy, safe, and desired sexual practices. (Bridges et al., 2010; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott & Schuler, 2011; and Wright et al., 2015.)

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.

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. <u>Theories of Sexual Offending</u>, John Wiley & Sons, Ltd. 2006).

Treatment Modalities

An integral part of an overall structured Level Six program is to decrease criminogenic risk factors and sexually abusive behavior problems. 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-abuse 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 high risk 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 offending, and development of coping strategies specific to each factor to interrupt unhealthy patterns of behavior and establish a self-regulation plan and competency and coping skills (protective factors) 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/ATSA/Safer Society trained sex-specific clinicians should use a psychosexual education curriculum that specifically addresses the unique characteristics and needs 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 (See Good Lives Model). 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 sexual 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., Zoom, Skype etc.) when circumstances impede the ability to engage in in-person sessions. 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, as needed.

Monitoring

Level Six community-based placement provides maximum, staff-secure 24-hour supervision and intensive sex-specific clinical intervention. Youth in sex-specific residential placements are typically (although not always) in the custody of the State. The juvenile justice authority or the placing professional (i.e., parent, Educational Consultant), and NOJOS/ATSA certified sex-specific clinician and the Level Six program treatment team act as an intervention team to ensure the youth’s well-being, compliance, and progression in the treatment program.

In a long-term sex-specific residential treatment programs, youth are monitored therapeutically and by residential staff with a State Licensure determined staff to client to ratio. If home visits are approved, parents are expected to report to the treatment team 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: (See Treatment Process For Discharge Section above)

Youth admitted to sex-specific residential intensive treatment have significant abusive-behavior patterns that typically require longer term treatment intervention and often require several months of follow-up community-based aftercare services following discharge (given the fact that they have had very little opportunity to test and refine self-regulation and risk management skills in the community. Nevertheless, treatment should always be individualized and tailored to each youth’s unique risk, needs and responsivity. Accordingly, some youth can stabilize more quickly, and based on progress and updated assessment, step-down to a less restrictive level of care to complete treatment.

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 Level Six youth to address issues related to their reintegration back home and 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.

Overall, it is imperative that Level Six treatment providers create a clear plan for 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. Specifically, Level Six clinicians and practitioners should review the adolescent's and family's progress toward attainment of youth's individual goals and objectives related to decreasing risk and promoting healthy functioning when making decisions about successful discharge from treatment recognizing the risk and needs associated with the change of environment after leaving a higher level of supervision, structure, and intensity of treatment support.

Treatment professionals should coordinate with one another through a youth's change in placement and treatment setting and/or provider and if possible, provide a handoff transition therapy session with the youth involving the Level Six and the step down therapist. This creates continuity and supports the intention for continuation of ongoing sex-specific treatment in the step down setting. This process also ensures that the youth see ongoing therapy after discharge as an extension of the Level Six intervention as opposed to "starting over" in treatment.

Given the high risk presented by youth requiring a Level Six placement careful updated sex-specific assessment should be made to determine appropriate and safe timing of the youth's discharge. 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 *Further, as detailed in the NOJOS Assessment Protocol, an updated sex-specific assessment is recommended prior to any discharge or step-down.*