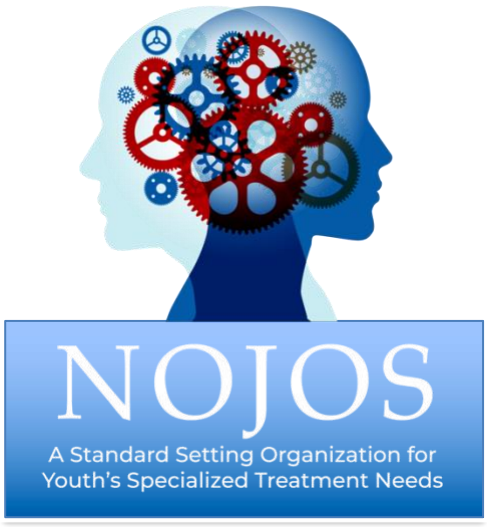


ADOLESCENT TREATMENT AND PLACEMENT PROTOCOLS AND STANDARDS MANUAL

Seventh
Edition

WELCOME NOTE

For the last 29 years, the Network on Juveniles Offending Sexually (NOJOS) has been actively involved in developing and sustaining standards for the assessment and treatment of youth who engage in problematic sexual behaviors and sexually abusive behaviors. The first Standards and Protocols Manual ["NOJOS Manual"] was completed in 1994. The NOJOS Manual has been updated several times over the years as new research and the national standards indicate. The intention is to keep the NOJOS standards aligned with national best practice standards, and current research and evidence-based outcomes. This latest 2023 update integrates both new research and national standards with the goal of giving the youth and their families the best possibility of achieving healing and the healthiest, and safest, possible outcome.

Over the years research and experience has informed us and helped us to gain a better understanding of juvenile sexual development and how to provide sex-specific intervention without causing harm. We now know that well intentioned interactions, procedures, and interventions can be misdirected and even harmful without a proper understanding of what is normative and expected at differing stages of child and adolescent development (and specifically *sexual* development). We have also learned that even referring to youth as "juvenile sexual offenders" and/or referring to all problematic sexual behavior as "offenses" or "offending" has the potential to undermine efforts to assist the youth we work with to heal and fully return to a healthy developmental trajectory.

Indeed, as documented by the Adolescent Practice Standards by the Association For the Treatment of Sex Abuse:

> *Although the term "juvenile sex offender" implies a legal status in some juvenile justice systems, these kinds of labels have the potential to negatively shape a young person's identity and self-concept during an important developmental period through which he/she might otherwise successfully navigate. Such labels are misleading, unhelpful, and at times harmful to the youth, his/her family, and/or the treatment process. ATSA selected the term "abusive" to refer to sexual conduct that is interpersonally harmful to distinguish it from other sexual behaviors that may be potentially problematic but do not harm another person. Finally, the term "adolescents who have engaged in sexually abusive behavior" describes rather than labels and denotes that this is a past behavior rather than a current or future one, which helps the adolescent, practitioner, and public expect correction of the youth's harmful behavior.* [Page 4.]

Importantly, members of the NOJOS community agree, this careful and intentional use of non-labeling terminology is in no way intended to minimize the harm caused to victims of sexual abuse or the egregious nature of sexually abusive behavior. Sexual abuse can cause grave harm, may have long-lasting impacts on the people victimized and their families and communities and may require legal interventions and specialized treatment. Effective clinical practice and public policy, informed

by sound research and an understanding of these youth, are essential to successfully address and prevent sexual abuse.

It is also important to note, research and evidence-based practice shows that sexually abusive behavior in adolescence rarely persists into adulthood. The vast majority of adolescents who have engaged in sexually abusive behavior do not continue to sexually abuse and are not on a life trajectory for repeat offending. Indeed, the majority of individuals who have engaged in sexually harmful behavior as a child or adolescent can, and do grow up, to be successful, prosocial, and happy individuals.

It is with this hope and possibility in mind that this updated version of the NOJOS Protocols and Standards have been written.

WITH THANKS

NOJOS wishes to express immense gratitude to the many individuals who have worked tirelessly with youth with problematic sexual behavior and who have contributed to the writing of this manual and all of its updating through the years. Without the passion, expertise, and commitment of these individuals, NOJOS would not exist. Thanks to each and every person who has contributed to this version and earlier versions of this manual.

The NOJOS Risk-Need-Responsivity (RNR) Continuum

Empirical Framework

The Risk-Need-Responsivity Principles (RNR) provide the empirical framework for the NOJOS treatment-placement continuum. The RNR model is based on an evidence-based framework that supports effective treatment and management of adolescents who have engaged in sexually abusive behavior. As documented in the ATSA Adolescent Practice Guidelines (2017):

> **Risk**: The Risk principle focuses on factors within the adolescent and his/her environment associated with sexual and/or general reoffending. Consistent with this principle, the number and constellation of a youth's risk factors, as established, and identified through appropriate assessment, determine a youth's need for structure and supervision as well as the intensity of treatment services. Adolescents with the highest risk are provided the most intensive services in more restrictive settings.
>
> **Need:** The Need principle focuses on dynamic risk factors that, if modified, would reduce the adolescent's risk for sexual or general reoffending. This principle ensures the target and focus of interventions are directly related to the dynamic risk factors for reoffending that have been assessed as present for the individual youth. Other factors that are present, but not necessarily empirically related to recidivism, also may be addressed to support the well-being of the youth.
>
> **Responsivity:** The Responsivity principle incorporates effective methods to maximize the adolescent's and his/her family's ability to benefit and learn from rehabilitative interventions. This principle states that interventions are to be delivered in ways that are sensitive and responsive to the youth's learning style, cognitive or developmental strengths and challenges, mental health status, psychological characteristics, and motivation to change, as well as his/her relevant cultural, gender, and other individual and family factors that affect the youth's and his/her family's ability to positively engage in and respond to interventions. This principle also notes the need to adapt and adjust the treatment and interventions as the adolescent matures and changes, or as more information is acquired that would suggest appropriate modifications. [Page 13-14.]

Intended Scope, Applicability and Use

These protocols and standards focus on adolescents ages 13 through 17; however, youth vary in their cognitive and psychological development. Therefore, NOJOS considers this age range to be advisory and recognizes there are times when these guidelines may be reasonably applicable and helpful in working with youth outside of the specified age range.

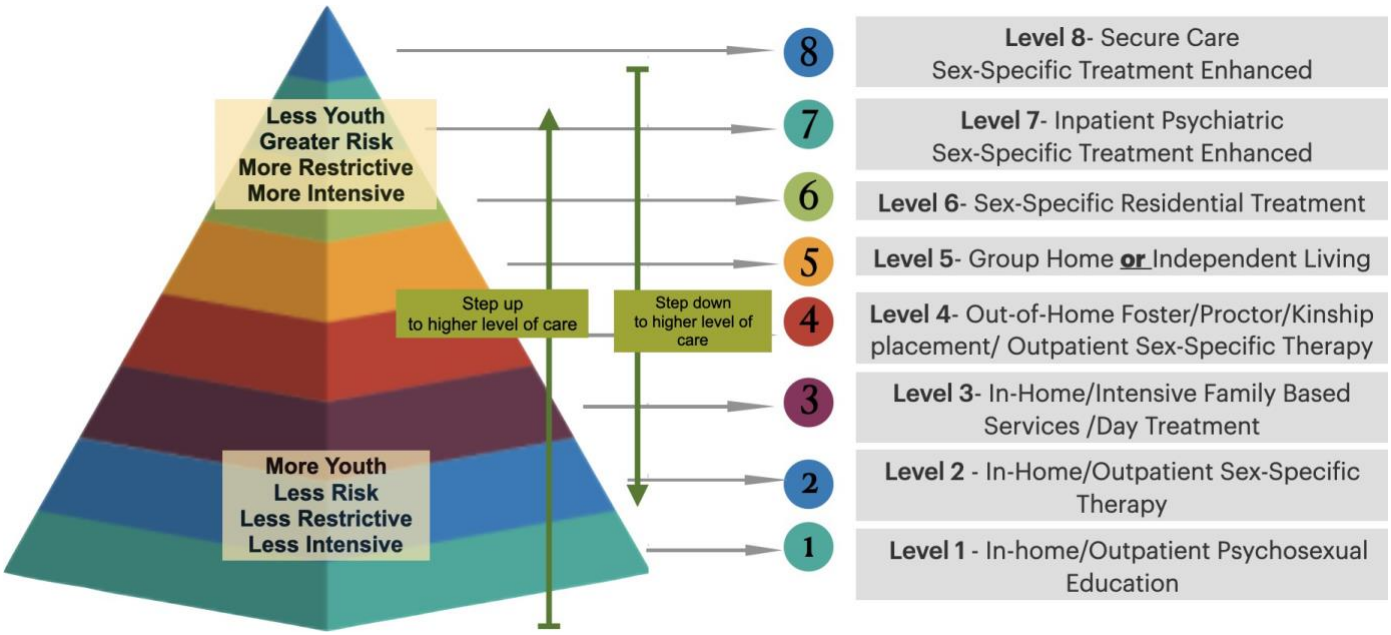
Further, for information on children with sexual behavior problems who are 12 years and younger, please refer NOJOS Protocols and Standards for Children and Latency Age Youth with Problematic Sexual Behaviors.

See also, the Report of the ATSA Task Force on Children with Sexual Behavior Problems (2006). Additionally, for information specific to individuals with intellectual disabilities and problematic sexual behavior, please refer to Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors (2014), or the Assessment and Treatment of Adolescents with Intellectual Disabilities Who Exhibit Sexual Problems or Offending Behaviors (2015). Further, for information on adult males who have sexually offended, refer to ATSA Practice Guidelines for Assessment, Treatment, and Management of Male Adult Sexual Abusers (2014). These and other resources are available on the ATSA website at www.atsa.com.

The positions articulated in these protocols and standards are intended to serve as recommended, current best practices for practitioners providing services to adolescents who have engaged in problematic sexual behaviors and/or sexually abusive behavior. These guidelines are not intended to replace any local, state, provincial, or federal statutes, provisions, mandates, promulgated ethical codes, or practice requirements/parameters established for regulated professions. Practitioners are encouraged to take steps to achieve an appropriate resolution in cases where a conflict between these standards and legal and professional obligations occur.

The NOJOS Treatment-Placement Continuum

Sexually abusive youth are best rehabilitated with a continuum of care and services based on their risk, needs and responsivity. The NOJOS Continuum consists of the following eight levels, beginning with the least restrictive "Level One" to most restrictive "Level Eight" as follows:



Although the NOJOS Continuum consists of eight levels of treatment intervention and supervision, ***the levels are not rigidly defined categories***, but rather guidelines defined by balancing managing risk, targeting and treating individual criminogenic, emotional, social and familial needs, and ensuring that treatment services provided are provided at the level of intensity required as well as tailored to the learning style, personality, biosocial characteristics, motivation, abilities and strengths of the youth (responsivity). For example, a youth may present with a moderate degree of sexual risk but has a family system capable of adequately supervising the youth in the home with the assistance of outpatient sex-specific therapy and/or adding in-home intensive family based services. Some individuals may need to first deal with their debilitating anxiety or mental disorder in order to successfully participate fully in a program targeting criminogenic needs. Further, other youth may have limited verbal skills and a concrete thinking style necessitating that the treatment intervention program ensure that abstract concepts are kept to a minimum and there is more behavioral practice than talking. ***These examples demonstrate how a sex-specific assessment needs to provide specific recommendations based on the individual's specific context, functioning, needs, and circumstances.***

Continuum of Care

1. Placement should correspond to the specific individualized needs and risk level of the client.

   The risk and need should be measured by examining the client's impulse control, risk factors and protective factors, and (with the possible exception of NOJOS Level 1), through a Sexual Behavioral Risk Assessment (SBRA) or equivalent sex-specific assessment.
2. 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 needs.
3. Initially, clients can be referred to any level of the continuum that corresponds to their diagnosed level of risk and identified needs; however, decisions regarding movement to less restrictive placements should be competency based.
4. The entire continuum of care should use the same sex abuse-specific assessment and treatment criteria in accordance with current research and professional standard of care. Thus, while specific placements may emphasize different aspects of sex-specific treatment, all placements should adhere to the outcome and research-based best practice standards. Sex-specific treatment that takes place in other than outpatient settings, (i.e., residential or day programs), should incorporate sexual-specific milieu supervision and treatment. As such, all staff in those placements should be trained:

   a. to provide clinically directed sex-specific interventions as part of their work with youth;
   b. to integrate the basics of sex-specific treatment into interventions that do not involve sexually abusive behaviors; and
   c. to integrate sex-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-specific programs per se.

5. Whenever possible, service providers should remain consistent as a youth moves from one level of the continuum to another (i.e., probation officer, case worker, therapists).
6. Placements along the continuum should be evaluated:

   a. by professionals trained in both evaluation methodology and sex-specific assessment and treatment; and
   b. according to sex-specific criteria agreed to in advance by evaluators and those being evaluated.

7. The continuum should include long-term self-help competency skills and require community safety and healthy living components.
8. Day programs and educational placements should be thoroughly integrated into the continuum of care and be required to provide sex-specific treatment.
9. 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., mood disorders, thought disorders, ADHD, ASD, and other neurological criteria). (See Assessment Protocols and Standards section.)

In general, the following guidelines are recommended when making in-home verses out-of-home placement decisions:

In Home Placement <u>should</u> be considered when:

- It is in everyone's best interest;
- The youth is a relatively low risk offender;
- The youth 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 <u>should not</u> 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 <u>should not</u> 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, <u>Risk Assessment of Youth Who Have Sexually Abused</u>, Prescott, David S., LICSW, Wood & Barnes Publishing, 2006, page 80-81).

Best Practice Standard
for 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. Overall, goals include promoting safety, healing, 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 and the environment they live in.

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 divert the youth on a pathway to engage in problematic sexual behaviors and/or sexually abusive behaviors.

"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 comorbid 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). NOJOS Juvenile Sex-Specific Assessment Protocol and Rubric

Consistent with the Utah NOJOS Continuum: "Treatment services are best offered and provided along a continuum of care – from community-based (outpatient) interventions to secure residential or correctional-based treatment programs. To be most successful, the level of intensity and restrictiveness of services must match the current treatment and supervision needs

which, depending on the youth and his/her family and circumstances, are likely to change over time. Most adolescents can be safely treated in community settings. Residential and correctional settings should be reserved for the minority of youth who present with significant risk factors for recidivism or other treatment needs that cannot be met in community settings." [ATSA Adolescent Practice Guidelines, 2017, page 47.]

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).

Moreover, a strength-based approach is strongly recommended given that protective factors can have a great impact on decreasing risk and helping the youth in making healthy life choices. Indeed, strengths-based factors help keep youth and their families positively engaged while mitigating risk factors and promoting healthy, prosocial ways for getting needs met, which are all essential components for effective treatment services (See Strengths-Based Alternatives for Mitigating Risk Factors in Youth and Family Services. ATSA Juvenile Practice Committee, September 2020; Powell, K. M. (2018). The importance of a strengths-based approach in sex offense-specific services. The Forum Newsletter-ATSA, Summer Vol. XXX, No. 3; J. Worling, 2017, PROFESOR).

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.

Many clinicians around the world currently support and have adopted what is called the "Good Lives Model," from The Juvenile Sex Offender, 2nd ed., by Howard Barbaree and William Marshall (New York, N.Y., Guilford Press, 2006). The Good Lives Model is a treatment approach that is based on the idea that successful treatment for persons with sexual behavior problems requires that they not only learn adaptive skills but also develop healthy lifestyles in order to prevent re-offense. The Good Lives Model suggests that material well-being, health, productivity, intimacy, safety, community, and emotion-al well-being are all critical components in helping clients develop "good lives." [Pathways Clinician's Guide by Timothy Kahn, Safer Society Press, 2023.]

Further, according to the "Good Lives Model*[1]," 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; See also, Yates and Prescott, 2011)

As part of a holistic approach, treatment should integrate standard sex-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 perspective taking, victim empathy and general caring for others. Overall, sex-specific components of treatment are founded in the restorative justice framework that emphasizes concern for development of victim empathy, restitution, and development of personal responsibility.

Treatment should also include positive 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.

Given that current research suggests exposure to pornography is now a common (developmentally expected) experience for both latency age and adolescent youth, psychoeducation about pornography is often needed to help adolescents think critically about pornography rather than solely focusing on teaching abstinence. Specifically, treatment should include a realistic, balanced, rational, developmentally sensitive, 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; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott & Schuler, 2011; and Wright et al., 2015.) [See also: ATSA Fact Sheet: Understanding and Responding to Pornography Use Among Adolescents Who Have Engaged in Sexually Abusive Behavior: Facts and Considerations for Practice, August 2020)

[1] The Good Lives Model is a strengths-based rehabilitation practice framework that augments the risk, need, and responsivity principles of effective correctional intervention through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with future offending. Originally developed as a rehabilitation framework for adults who have harmed others —when properly adapted—the GLM can be effectively used with adolescents and young men to address their sexually abusive behaviors.

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 protocols and practices support the holistic treatment of adolescents and children who have engaged in problematic sexual behavior, NOJOS supports the needs of those who experienced abuse and strongly recommends that ALL treatment decisions should support the healing of both those who engaged in sexually abusive behaviors and those who were victimized.

Best Practice Treatment Approach, Focus and Objectives

Utilization of the Risk, Need, and Responsivity Model in Sex-Specific Treatment

A holistic approach to treatment should also demonstrate an understanding that the majority of any recidivism 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 (sexual and non-sexual) recidivism. The main focus is then, through treatment, developing these into strengths and 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 focus of the Good Life's Model, Yates and Prescott, 2011.

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.)

As detailed above, 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).

Qualifications For Providers of Sex-Specific Assessment and Treatment

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 licensed master's level mental health professionals who have additional training and experience in working with adolescents, sexual abuse and sexual abuse issues and have been trained or certified by nationally and/or State recognized organizations (i.e., NOJOS, ATSA, Safer Society). [See NOJOS Clinical Certification section]

Specifically, at a minimum, mental health clinicians working with youth who engaged in sexual misconduct and/or sexually abusive behavior need to have specialized "sex-specific" training and experience 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, or at least a strong theory about, the dynamics of healthy sexual development and development of sexually abusive behavior including its onset, and maintenance over time [Rich, P. (2009). Juvenile Sexual Offenders: A Comprehensive Guide To Risk Evaluation. Hobokon, NJ: John Wiley]. See also, ATSA Adolescent Practice Guidelines, 2017].

Additional suggested areas of basic foundational training include the following:

- Child development, including typical sexual development and behavior
- Differential diagnosis of childhood mental health and behavioral problems
- Specific familiarity with common problems seen among children with sex behavior problems , including non-sexual disruptive behavior problems, learning disorders, ADHD, ASD and other developmental issues, child maltreatment, child sexual abuse, trauma, and posttraumatic stress related problems.
- Familiarity with conditions that may affect self-control, such as ADHD and childhood bipolar.
- Understanding environmental, family, parenting and social factors related to child
- behavior, including the factors related to the development of sexual and nonsexual attitude and behavior problems.
- Familiarity with the current research literature on empirically supported intervention and treatment approaches for childhood behavior and mental health problems.
- Cultural variations in norms, attitudes and beliefs about childrearing and childhood sexual behaviors.

Overall, sex-specific therapists should have the knowledge and skills necessary to provide effective interventions and adequately address youth responsivity factors and/or special needs by consulting with knowledgeable experts, accessing specialized training, and participating in other professional development activities as needed so as to remain apprised of contemporary research and evidence-based interventions for adolescents who have engaged in sexually abusive behavior.

Thus, those individuals providing targeted sex-specific therapy interventions (whether it is individual, family or group therapy), should be certified/trained by NOJOS/ATSA/Safer Society (or other best practice standard of care equivalent) as a licensed mental health clinician with sex-specific expertise and specialized professional training as outlined above.

Additionally, all practitioners should actively educate others including those involved in treatment, mental health, child welfare, juvenile justice, government, and policy making about these protocols and standards. Doing so will help promote current evidence-based and ethically sound practices; offer a measure of protection for adolescents, practitioners, and the public against unethical, non-informed, or unprofessional practices with this population; and serve as a catalyst for additional empirical research to further inform practices and policies regarding adolescents who have engaged in sexually abusive behavior.

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 training on children and adolescents with problematic sexual behavior. These service providers are also encouraged to attend annual NOJOS/ATSA/Safer Society sponsored trainings. All providers of adjunct paraprofessional services to youth with problematic sexual behaviors should work under the supervision of an experienced/certified sex-specific clinician. See ATSA Professional Guidelines-Code of Ethics

Treatment Process For Discharge

All clinicians should apply the RNR principles throughout the treatment process to inform treatment decisions including frequency, focus, and duration of treatment.

Practitioners recognize that decisions about when an adolescent moves within the RNR Continuum from an out-of-community placement are based on the individual youth's risk and needs, not on a pre-established curriculum, set of objectives or predetermined timeframes. Adolescents are moved to a less restrictive environment and less intensive services when their risk and needs support being safely served outside more restrictive and intensive settings.

Practitioners recognize and communicate that successful discharge from a treatment program/regimen indicates the adolescent and their caregivers, when appropriate, have demonstrated progress related to the goals and objectives of the adolescent's individualized treatment plan designed to reduce the adolescent's risk to reoffend and increase stability and prosocial behaviors to such a degree that the adolescent's level of risk and needs supports a decrease in intensity of services or the ending of formal treatment. Successful completion does not indicate the individual's risk to reoffend has been eliminated completely.

Sex-specific treatment providers and treatment programs should develop written treatment plan/agreement (e.g., treatment consent forms) to ensure clarity and agreement among the provider, adolescent, and legal custodian and caregivers, when appropriate. Such contracts address, at a minimum:

- the nature, goals, and objectives of treatment;
- the limits of confidentiality;
- the expected frequency and duration of treatment;
- rules and expectations of treatment program participants;
- responsibilities of the treatment provider;
- risks and benefits of participation and progress;
- consequences of noncompliance with program rules and expectations; and
- criteria used for assessing progress and determining program completion.

Practitioners should routinely use multiple methods to objectively and reliably gauge treatment progress, particularly with respect to dynamic risk factors. Including but not limited to behavioral information; structured, research-supported tests and inventories (as necessary; therapist evaluations; youth self-reports; and family and other collateral reports.

Clinicians should routinely review the adolescent's individual treatment plan and clearly document in treatment progress reports the specific and observable changes in factors associated with a youth's needs and risk to recidivate, or the lack of such changes.

Clinicians and practitioners should review the adolescent's and family's progress toward attainment of goals and objectives related to decreasing risk and promoting healthy functioning

when making decisions about successful discharge from treatment. According to the ATSA standards, an adolescent who is successfully discharged from treatment generally:

- has developed recognition of antecedents, behaviors, and consequences related to past sexually abusive behaviors and has a plan for avoiding, refusing, or altering such antecedents;
- demonstrates functional coping patterns when stressed;
- demonstrates the ability to manage anger, frustration, and unfavorable events;
- demonstrates self-protection skills;
- demonstrates prosocial relationship skills;
- has replaced inappropriate (or, in the case of social isolation, the absence of) peers and activities with prosocial peers and appropriately monitored prosocial activities;
- has developed, with his or her family, an understanding of appropriate dating, romantic, and sexual behaviors, and how these might change over time;
- has developed, with his or her family, a plan for successful school involvement; and
- when sexual interests of children, coercion, or force contributed to past sexually abusive behaviors, has developed a plan for addressing the occurrence of inappropriate sexual thoughts, fantasies, or behaviors.

[ATSA Practice Guidelines, 2017, pages 57- 60.] See NOJOS Discharge Criteria

Practitioners should help caregivers develop enhanced capacity to effectively supervise and monitor youth behavior, support, and reinforce responsible youth behavior, and consistently apply sanctions for inappropriate behavior.

Practitioners should only evaluate treatment progress within the context of a thorough understanding of the adolescent's individual capacities, abilities, vulnerabilities, and limitations. Associated recommendations should reference these factors and aim to stay within the bounds of what is likely or possible for the individual youth.

Practitioners providing community-based treatment recommend more intensive treatment and/or supervision if an adolescent experiences significant difficulties managing identified risk factors for sexual and nonsexual offending in a way that jeopardizes community safety.

Practitioners should prepare the adolescent and his/her family for discharge from treatment. This may include structured forays into the community to test and refine coping skills, home visits to ensure family stability and sustained boundaries, a gradual reduction in frequency of contacts over time as treatment gains are made, booster sessions to reinforce and assess maintenance of treatment gains, and coordination with future service providers.

Overall, treatment progress should also be based on the meeting the treatment goal is "to assist the adolescent 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).

Intervention duration should be guided by the risk-relevant needs of the youth and his/her family. Decisions about management and supervision are informed by the youth's protective factors, risk factors, and community safety. ATSA 2017 Adolescent Practice Guidelines and Appendix

THE EIGHT LEVELS IN THE NOJOS RNR TREATMENT-PLACEMENT CONTINUUM

1

NOJOS Level One: In-Home/Outpatient Psychosexual Education

Client Profile

Youth appropriate for NOJOS Risk Level One: In-Home/Outpatient Psychosexual Education intervention typically fall in one of two categories: (1) Younger children, latency age and adolescent youth with no previous known history of sexual acting out, or who have engaged in problematic sexual behavior (PSB) on one occasion, or who have displayed low-frequency problematic sexual behaviors. Sexual incidents are usually spontaneous, isolated, exploratory and/or situational in nature with no use of coercion or aggression, and there is no evidence of progression in their behavior; or (2) Adolescents who, in the course of a developmentally normative[2] consensual, " non-coercive" relationship, engage in sexual touching 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 typically have had little exposure to healthy sexual information and/or experiences, present with low culpability and their sexual behavior tends to be spontaneous and/or impulsive, infrequent, and less intrusive. They have little understanding of the inappropriate nature or impact of this type of behavior or their behavior. They may have gained sexual information beyond their developmental readiness. Their problematic sexual behaviors and/or sexual misconduct are usually as a result of deficits in their fund of sexual knowledge, misdirected attempts to connect socially, and/or limited understanding of consequences of their behavior rather than sexual deviancy.

These youth are typically 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.

Treatment Goals

Psychosexual Education interventions include public and private community-based mental health programs that provide a short-term, age-appropriate, psycho-educational module on human sexuality and healthy human sexual behavior, including detailed material on problematic sexual behaviors and 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*

[2] Moral, social, and/or familial rules may restrict these (developmentally normative) behaviors, but the behaviors are not *abnormal*, developmentally harmful and/or illegal when private, consensual, equal, and non-coercive. (Ryan, G. and Lane, S. Editors; Juvenile Sexual offending; Causes, Consequences, and Corrections, Jossey-Bass Press, 1997).

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). See also, ATSA Adolescent Practice Guidelines and Appendix (2017).

The primary goals of Psychosexual Education interventions are to:

1. Educate the youth to ensure that they understand what sexual behaviors are developmentally expected, appropriate and legal versus inappropriate and illegal, and understand and can demonstrate appropriate personal and social boundaries;
2. Develop and/or augment the youth's healthy fund of sexual education and knowledge;
3. Enhance their responsible adaptive level of functioning socially, emotionally, and sexually; and
4. Assist the youth on (or back on) a more normative sexual developmental trajectory.

Treatment Modalities

The primary modality at this level of need is a short-term psychosexual education intervention provided individually or in a group. The youth's family should also be included in the intervention process. The psychosexual education intervention should be short term, occur weekly, and be approximately two to three months (based on an individualized curriculum and the youth's specific need). This intervention **is not** traditional individual psychotherapy and should only be provided with a *psychoeducational* approach (although psychosexual education may occur in an individual clinical therapy session).

Psychosexual education interventions can include homework (individual and family assignments), Psycho-educational treatment interventions can include experiential exercises, sensory interventions, observation in the community, parent education, development of social skills. Additionally, if the youth has engaged in "hands on" problematic sexual behavior with an identified victim, additional *victim empathy work* may be necessary. This would typically require individual sessions but should only be done by catering to the youth's age, maturity level and/or neurodevelopmental abilities.

Overall, special attention should be given to each youth's learning abilities and learning style when determining how to use educational assignments. Further, workbooks should *only be used to supplement* the education provided rather than being the sole source or information and determinant of progress and/or completion of treatment at this level. Finally, providers should assess the youth's response to this intervention and provide ongoing assessment of any changes in risk and/or need.

NOJOS Level Two, outpatient sex-specific psychotherapy treatment interventions are contraindicated at this level. Moreover, every effort should be made to avoid the "contagion effect" for these youth by ensuring that all the youth participating in a psychosexual educational group are similar in age, development, and social ability, as well as sexual knowledge and risk. For example, it would be inappropriate for a low risk Level One psychosexual education youth to participate in an outpatient sex-specific therapy group and/or be introduced to targeted sex-specific curriculum (where detailed information about sexual-offense behavior is discussed or where the lower risk youth is exposed to additional problematic and/or deviant sexual

information.

Treatment is more about aiding youth to understand their sexuality (physiological sensations, thoughts, feelings, and behavior) and sexual development, owning responsibility for their sexuality and sexual behavior, identifying that there is impact and potential consequences for how they choose to explore and express their sexuality, and helping them enter, or return to, a more healthy, normative developmental pathway for their sexuality.

In some circumstances some youth may need traditional *non-sex-specific psychotherapy* to address coexisting mental health disorders and Level One Psychosexual Education as an adjunct to address the youth's sexual misbehavior/functioning. Further, in rare circumstances, where the youth present as vulnerable and naïve (i.e., extremely immature, low ego strength, etc.), group intervention may not be beneficial and even contraindicated.

Treatment Focus

Group or individual psychosexual education should follow a short term structured curriculum, ideally including both the youth and their parent(s) or primary caregiver(s) in the process. The intervention should incorporate, enhance, and provide developmentally appropriate psychosexual education. Some areas for consideration include following:

- General sex education (including maturation, sexual anatomy, sexual physiological responses, etc.);
- Sexuality education—recognition they are a sexual being and sexuality is a part of being human and their current stage of development; that sex has meaning and purpose in life, and an understanding of what meaning sex has 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, boundaries, and behavior;
- Developmentally expected child/adolescent sexual behaviors and sexual development;
- Psychoeducation about pornography is often needed to help youth think critically about pornography and understand its potential risks rather than solely focusing on teaching abstinence;
- Current abuse laws and consequences governing sexual behavior;
- Accountability;
- Values clarification and healthy sexual attitudes;
- Self-esteem and healthy identity development, including positive body image;
- Teaching basic emotional and self-regulation skills;
- Identification and healthy expression of feelings (including anger);
- Basic stress management and emotional-coping skills;
- Increased understanding of interpersonal boundaries;
- Perspective-taking skills and empathy development;
- Interpersonal relationship skills and assertiveness; and.
- For those with hands-on victims, clarification work should be included.
- For some creation of an individualized safety and supervision plan may be included.

Overall, treatment providers should use a systematic approach to observe, test, evaluate, and measure the *individualized* attainment of the psycho-sexual education information provided (beyond the youth's simple completion of workbook assignments).

Treatment Providers

NOJOS Risk Level One: In-Home/Outpatient Psychosexual Education intervention can be provided by any licensed mental health clinician, or by a clinical intern or paraprofessional (supervised by a licensed mental health clinician) with some training in the areas detailed in the *Qualifications For Providers of Sex-Specific Assessment and Treatment Section above.*

Monitoring and Safety Plan Compliance

Sex-specific trained clinicians/supervised paraprofessionals and the youth's parents/guardians monitor non-adjudicated youth while the Juvenile Court and probation monitor adjudicated youth 13-years-old and older.

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NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy

Client Profile

NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy youth not only need psychosexual information (outlined in NOJOS Level One above), but they also present with a need for targeted sex-specific clinical intervention. Typically, this is the first time these youth have every engaged in sexual misconduct or they may have successfully graduated from a higher level of care and now need ongoing outpatient Level Two services for step-down transitional, and aftercare purposes. These youth may present with a slightly greater frequency and duration of problematic sexual behavior and/or sexual misconduct than a Level One youth and thus, they fall in the *low risk or low-to-moderate risk level.*

Youth qualifying for this level of intervention typically have one or more victims, but usually do not have indiscriminate choice of victims (i.e., male, and female victims, related/unrelated victims and/or toddler and peer/adult victims). Their sexual behavior may have been more intrusive, but nevertheless, showed minimal evidence of progression from less-intrusive to more-intrusive sexual behaviors over time/across victims. 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) possess 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 an 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 (although not always and often not initially). 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 of sexual behavior on others, or they have comorbid neuropsychological barriers that have prevented their development of empathy. These youth typically present with adequate community support, are willing and able to comply with safety restrictions and are usually amenable to treatment.

The majority of these youth are *low risk and/or low-to-moderate risk* as assessed by nationally recognized risk assessment tools. The significant difference between youth who qualify for outpatient sex-specific clinical intervention and those requiring more intensive intervention lies in the protective factors, resiliency and internal and external assets of these youth and the availability of a competent caregiver with current capacity to provide adequate safety, supervision, and guidance.

In limited circumstances, these youth may present with a moderate level 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 acceptable protective factor to reduce the youth's risk. These youth typically do not present with a strong pattern of oppositional behavior or conduct disorder; however, they may present with other comorbid diagnoses including clinically significant depressive symptoms, anxiety and/or impulsivity/attention problems.

Overall, youth who qualify for Level Two Outpatient Sex-Specific Psychotherapy intervention typically present with more protective factors both internally, and in their family system and home environment, as well as their meso-system (school, church, social group, neighborhood etc.) These youth also often have higher levels of resiliency and internal assets that help lower and offset their risk.

Treatment Focus and Goals

NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy interventions should provide individual and family therapy, as needed, offering traditional adjunct mental-health services (with individualized dosage and variations in focus, model, and duration) and sex-specific services. Group therapy may be appropriate *in some circumstances but not always necessary for this level of intervention*. Level Two providers should provide sex abuse-specific interventions, cognitive behavioral content, risk management, and strength-based skill building. 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.

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).

Given that current research suggests exposure to pornography is now a common (developmentally expected) experience for both latency age and adolescent youth, psychoeducation about pornography is often needed to help adolescents think critically about pornography rather than solely focusing on teaching abstinence. Specifically, treatment should include a realistic, balanced, rational, developmentally sensitive, 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. (See Bridges et al., 2010; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott &

Schuler, 2011; and Wright et al., 2015.) [ATSA Fact Sheet: Understanding and Responding to Pornography Use Among Adolescents Who Have Engaged in Sexually Abusive Behavior: Facts and Considerations for Practice, August 2020]

Psychoeducation points to consider in treatment interventions related to pornography include:

> 1.Pornography portrays sexual performances and behaviors that are generally scripted and unreal, depicted by actors, and not representative of real-life sexual behavior or healthy, safe, enjoyable sexual experiences for all involved parties; 2. In many scripted pornography scenarios, sexual practices that are depicted are unhygienic, aggressive or violent, and if used in actual sexual practice, may result in physical or emotional injuries; 3. Pornography depicts aggression, in particular aggressive sexual behaviors, as desirable to all involved parties, when this is not the case in most real-life sexual relationships; and 4. Pornography may negatively impact body image due to the use of actors who do not represent 'average' physical norms. (See Bridges et al., 2010; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott & Schuler, 2011; and Wright et al., 2015.) [ATSA Fact Sheet: Understanding and Responding to Pornography Use Among Adolescents Who Have Engaged in Sexually Abusive Behavior: Facts and Considerations for Practice, August 2020.]

Overall, the goal for NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy 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). [See also Good Lives Model, Yates & Prescott, 2011; .]

Treatment Modalities

Based on the youth's presenting problems and needs assessment. Outpatient sex-specific treatment can vary in focus, intensity, duration, and frequency. This is typically related to the youth's response to treatment as well as their ability to obtain primary human goods or common life goals (See Good Life Model Treatment Goals including living and surviving, learning, and knowing, being good at work and play, personal choice and independence, peace of mind, relationships, and friendships, being part of a group or community, spirituality and having meaning in life, and happiness and creativity, Yates & Prescott, 2011). Nevertheless, this Level of treatment must include psychosexual education **and** targeted sex-specific therapy at least weekly for the specific risk factors and etiological deficits identified in a comprehensive sex-specific assessment as contributing to the youth's sexual misconduct. Traditional mental-health therapy interventions should also be included to address the youth's other comorbid psychological issues.

Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety planning and assisting the youth to manage

his/her risk. Family therapy should also include education of the parents/caregivers[3] regarding the youth's current risk factors, treatment goals and supervision needs and skills to provide healthy sexual development after treatment ends. Indeed, it is critical to view the parent(s)/guardian(s) as part of the treatment team and empower them to be active participants in the youth's treatment process. 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.

Monitoring and Safety Plan Compliance

The NOJOS certified sex-specific clinician(s), and parents (and other informed caregiver(s)/ supervisors, case worker, etc.) act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. The safety plan and supervision guidelines should identify those informed 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 (academic, community, family, religious) activities.

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

3

NOJOS Level Three: In-Home/Intensive Family-Based/School-Based/Day Treatment Sex-Specific Services

Client Profile

Youth appropriate for Level Three Intensive Family Based, School Based and Sex-Specific Day Treatment differ from Level One and Level Two Outpatient Intervention youth in that they have significant environmental, peer or family-based risk factors, and/or additional deficits in executive functioning and/or behavior management in their school and/or home environment requiring more supervision. Specifically, these youth present with significant family and home environment based risk factors, and present with supervision risks, non-compliance behavior problems, comorbid clinically significant mental health issues and/or executive functioning problems that cannot be managed or addressed effectively in a traditional school setting. Of note, many youth often have preexisting comorbid mental health issues and may have been in treatment prior to engaging in problematic sexual behaviors.

The significant difference between youth who qualify for Level Two outpatient sex-specific clinical intervention and those requiring Level Three intensive sex-specific intervention lies in the absence or presence of protective factors, resiliency, internal and external assets of these youth and the safety and stability of their home and school environments, particularly the availability of a competent caregiver with current capacity to provide adequate safety, supervision, structure and guidance. Overall, intensive services serve to bolster the youth's family system and home and school environments to actively help reduce the youth's personal, family, and environmental risk factors such that the youth can safely remain in their home and academic environments.

Treatment Focus and Modalities

Research indicates clearly that harmful sexual behavior is associated with myriad developmental and environmental factors such as disability, mental health difficulties, exposure to domestic and family violence, harmful gender norms, and use of pornography (Kenny Kor, et al., 2023). Effective treatments include attention to meet the needs, vulnerabilities, protective factors and strengths of the individual adolescent and their family and respond to the variety of issues that may be present (Chaffin, 2008). When sexual behavior/abusive problems are the primary problem, research-supported, evidence-informed sex-specific treatment should be considered. When sexual behavior is a secondary focus, using well-supported, evidence-based treatment matched to the highest-priority comorbid problem combined with sexual behavior problem-focused components should be considered (Allen, 2018).

Overall, intensive sex-specific interventions can be interpreted and implemented with several combinations of services depending on the individual treatment needs, responsivity, and risk as determined by the youth's assessment. Specific evidenced based models may be used or

incorporated to guide interventions e.g., Cognitive Behavior Therapy, Multi Systemic Therapy (Henggler), Functional Family Therapy (Alexander), Family Strengthening Program (Kumpfer), the Good Lives Model (Yates &Prescott, 2011), the Teaching-Family Model (Families First).

Intensive family interventions that include teaching and monitoring using paraprofessionals and wraparound services may also be effective, depending on the need. Wraparound services are a multifaceted, system-level intervention designed to keep youths with serious emotional and behavior disorders (SEBDs) at home and out of institutions whenever possible (Suter and Bruns 2006; Bruns et al. 2010; Winters and Metz 2009). As the name suggests, this process involves "wrapping" a comprehensive array of individualized services and support networks "around" young people in the community rather than forcing them to enroll in predetermined, inflexible treatment programs (National Wraparound Initiative Advisory Group 2003).

Intensive Family Based Services

Some youth with significant family system issues can be maintained in the home with added Intensive Family Based Services (IFBS) in addition to their sex-specific individual, family, and/or group therapy. IFBS can include in-home counseling and psychoeducation regarding family boundaries, safety planning, and behavioral management interventions. Level Three youth need services that are intensive, and family based to help address their problematic sexual behaviors, general oppositional or unruly behaviors, as well as the family environment that contributes to their ongoing risk and establishing a safety plan.

IFBS targets the youth's unhealthy or risky home environmental factors, family history of abuse and neglect, parental supervision and boundaries, other mental health issues impacting the youth's sexual and non-sexual behavior problems and attachment issues. Level Three youth usually have significant family risk factors and some behavior problems, but also often have good support from extended family and their community and/or other strengths that can be mobilized through an IFBS allowing them to remain safely in the home and community.

Intensive Family Based Services should provide intensive, short term in-home counseling and psychoeducational services that target specific youth needs and/or risk factors identified in the initial risk assessment related to the family system and environmental factors contributing to the youth's risk/needs (i.e., healthy boundaries, healthy sexual education, roles in the family and family structure, productive family communication patterns, problem solving skills, conflict resolution, effective parenting skills and appropriate supervision and discipline, etc.).

Intensive Environmental Support Services/Day Treatment

Some Level Three youth present with sexual supervision risks, oppositionality, non-compliance behavior problems, comorbid clinically significant mental health issues and/or executive functioning problems that cannot be managed or addressed effectively without additional support and informed supervision in school. Indeed, they often require additional therapeutic support, structure, and safety planning during the school hours. Further, in some cases where these additional in-school and community supports are ineffective, they must be removed from their academic setting and placed in a day treatment program. First and foremost, these

settings must be able to provide *informed supervision of the youth's sexual risk and behavioral problems*. For this reason, placement of a Level Three youth in a day treatment program should be evaluated on a case-by-case basis to ensure that the Level Three youth does not pose too great a risk to the other non-offending youth in the program yet can adequately receive the informed supervision needed.

The length of Level Three intensive services depends on the risk and needs of the youth, as well as the needs and capabilities of the youth's family system, environmental factors, and caregivers. Further, once Level Three youth and the family have created a safe, healthy, stable, and predictable environment, "*discharge*" to a lower level of care should be considered. This includes youth who no longer need the intensive family based and/or environmental services and support yet need to complete their sex-specific therapy.

Intensive sex-specific services also provide an important step-down service for youth transitioning from higher levels of out-of-home care and supporting their transition back home.

Monitoring and Safety Plan Compliance

The NOJOS certified sex-specific clinician(s), and parents (and other informed caregiver(s)/ supervisors, case worker, etc.) act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. The safety plan and supervision guidelines should identify those informed 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 (academic, community, family, religious) activities.

4

NOJOS Level Four: Out-of-Home Sex-Specific Treatment (Kinship/Foster/Proctor/Transition to Adult Living)

Client Profile

Youth appropriate for NOJOS Level Four Out-of-Home Sex-Specific Treatment intervention present with *low-to-moderate or moderate risk* including: (1) Risk that cannot be controlled in their current living environment; and/or (2) Parents and caregivers who cannot or will not provide adequate supervision. For example, the youth's removal from home may be 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. (3) Other youth may require short term out-of-home intervention due to parents/caregivers who do not provide an adequate healthy or safe living environment for the youth; and/or (4) The youth's environmental risks include immediate or near-immediate access to victim(s) or potential victim(s) that cannot be adequately supervised. (5) Finally, some youth also fall into this level of care because they are not able to continue residing at home because their 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. (Of note this last category of youth often fall at a lower level of risk commensurate with lower NOJOS levels including in-home outpatient treatment options; however, are being place out of the home due to the needs of their in-home sibling victims. *Accordingly, sex-specific assessment evaluators should specifically document the reason(s) for the recommended removal to ensure these lower risk youth are not perceived at a higher risk due to the recommended removal to accommodate the competing needs of their sibling victim.)* Overall, these youth typically present as either *low-to-moderate or moderate risk* to the community as assessed by nationally recognized risk assessment tools and are in need of a placement based on issues within their environment.

NOJOS Level Four Out-of-Home Sex-Specific Treatment intervention is typically the first out-of-home alternative available on the NOJOS treatment continuum for youth who require removal from their current home environment. As detailed above, these youth typically require more-intensive structure and supervision than what is available in their current home setting or must leave the home to accommodate a victim's healing, safety and well-being who is still residing in the home.

Additionally, when needed this level is appropriate for youth who require a transitional step-down placement to practice, generalize and apply the skills learned in a more highly structured group treatment environment before being safely returned to the community.

As noted above appropriateness for placement in NOJOS Level Four Out-of-Home Sex-Specific Treatment intervention is based on the following criteria related to deficits or issues in family functioning, home environment, and/or caregiver willingness and ability to provide proper supervision and/or the youth's regular participation in treatment as follows:

1. Family 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 needed to address the youth's risk and/or treatment and/or supervision needs;
2. The adult caregivers are incapable of, or choose not to, provide the level of structure and supervision required to prevent sexual misconduct or assist the youth to deal with his/her treatment needs;
3. The family, through their own behaviors, values, and issues, do not provide a healthy environment for youth to heal and rehabilitate;
4. The family presents as enabling and/or denial-based mindset undermining the youth's responsivity to interventions or safety and well-being of victims in the home;
5. 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).

NOJOS Level Four Out-of-Home Sex-Specific Treatment should be short term and individualized to the youth's age, level of maturity, and sexual and nonsexual risk to ensure they are placed with other youth similar to their level of functioning are not placed with individuals similar in age to the youth's victim(s), and/or potential/possible victims, and/or older offending youth (that could expose the youth to contagion and/or the risk of being victimized themselves). Careful consideration of contracts, ethics, licensing, and other best practices should be considered when determining age, ability, disability, history, and legal status as compared to other residents of the out-of-home placement and treatment group. Moreover, if the youth with problematic sexual behavior presents with risk to those younger than himself/herself, he or she should not be placed in an out-of-home care setting with younger children or peers.

Some NOJOS Level Four Out-of-Home Sex-Specific Treatment youth are Court ordered into State's custody under the supervision of the Department of Health, Division of Child and Family Services (DCFS) or Division of Juvenile justice Services (DJJS) who will provide, or who will contract with providers for sex-specific placement and treatment services. DCFS typically utilizes *foster-home* placements, and DJJS utilizes *proctor-home* placements. In many cases, out-of-home youth are charged and adjudicated for their sexual delinquency in the Juvenile Court.

It is recommended out-of-home family based settings should have at most one or two additional proctor/foster residents in the same household. If the youth with problematic sexual behavior presents a risk to same-age peers and/or younger children, the youth must be placed in an out-of-home care home *with no other youth residing in the home*. In this later circumstance, care should also be taken to ensure that even though other youth do not reside in the home, they also do not visit the home without proper informed supervision.

Step-Down and Step-Up Transitions

1. Youth transitioning down from a higher level of care are also appropriate for a NOJOS Level Four short term out-of-home care setting as a step-down option into family-based

care. In this situation, this level of care provides a less-restrictive environment for transition and practice of skills learned in more-intensive group residential settings (NOJOS Level five and six) and/or secure care settings (NOJOS Level eight).

Additionally, those youth who have successfully reduced risk and progressed and stabilized in treatment at a higher level of care, (such as a moderate-to-high risk youth in a NOJOS Level five setting and/or high risk youth in a NOJOS Level six residential setting), may transition (step-down) to a family-based out-of-home setting, where they receive structure and supervision and are able to continue and complete their sex-specific treatment through Level Two outpatient sex specific treatment aftercare services. This option provides the opportunity for the youth to test and refine coping and competency skills before being completely returned to the community without supervision or having had the opportunity to experience forays into the community. *As detailed in lower levels of care family therapy are recommended for all youth who will be returning home. In some cases, in-home family based services-IFBS may also be needed*.

2. NOJOS Level Four moderate-level risk treatment youth also include adolescents who are failing, or who have failed, at a lower level of treatment intervention. However, to qualify for out-of-home care, the failure is typically a result of environmental or familial issues rather than related to the youth's conduct or increase in risk. Furthermore, youth who fail at a lower treatment intervention because of their conduct, resulting in an increased treatment need, may require a step-up to short term out-of-home care based on their increased current management, risk, behaviors, and treatment needs.

3. Clearly, step-down, and step-up transition decisions require current sex-specific assessment of the youth's risk, need and responsivity to ensure selection of a proper level of treatment and supervision.

Treatment Focus and Goals

NOJOS Level Four Out-of-Home Sex-Specific Treatment youth must meet the sex-specific discharge criteria outlined earlier in these Protocols and Standards. Further, as discussed previously, the Association for the Treatment of Sexual Abusers (ATSA 2017) 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 (common life goals) 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).

Given that family reunification is a primary goal, treatment should specifically focus on engaging the youth's parent(s) and family unit in family therapy to address family system/parent-child relationship and home environment based issues contributing to the need for out-of-home placement.

Specific care should be taken to ensure any in-home victim contact as part of this therapy follows the **NOJOS Clarification and Reunification** process: NOJOS Clarification-Reunification Protocol including coordination with the victim's therapist to determine mutual clinical readiness.

Monitoring

The sex-specific trained clinician and out-of-home caregivers and residential staff providing supervision, work together to monitor the youth's compliance in their living environment, school and in their sex-specific therapy. Youth who are Court ordered into State's custody will also be supervised by an assigned Department of Health case manager who will coordinate with the treatment team and provide oversight of the youth's treatment progress and placement. In some cases, Level Four youth receive additional tracking services to increase monitoring and social support (especially in making forays into the community). 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 and structured home visits.

The parent(s)/guardian(s)/supervisor(s)/tracker(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS/ATSA sex-specific licensed clinician and Division case manager after being educated on the youth's individual risk and supervision needs and a family safety and supervision plan has been established. It is strongly recommended that information regarding appropriate supervision techniques (to be utilized with sexually traumatized youth, hyper-sexualized youth and youth who present a risk to engage in sexual misconduct) is included as part of the parent/guardian/ supervisor/tracker training.

Criteria for Discharge (See Treatment Process For Discharge Section above)

The youth may be successfully discharged from NOJOS Level Four Out-of-Home Sex-Specific care when the sex-specific clinician, parent(s)/guardian(s) and Division case manager determine that the youth's problem behaviors can be successfully managed in a less-restrictive setting and the family is able and willing to provide adequate supervision. Parent(s)/guardian(s) must demonstrate they are able and willing to provide adequate supervision before the youth can be returned to their care.

Transfer to an outpatient sex-specific treatment program can allow the youth to continue to address sex-specific treatment goals while having clinically supported forays into the community to test and refine competency and coping skills. Treatment professionals should be careful to coordinate the transfer of treatment services and keep parents adequately informed and involved. Further, 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.

As in any NOJOS 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 out-of-home youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and reduced (including assessment of the well-being and safety/readiness of a victim still residing in the home);
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized/managed effectively;
4. Risk has been lowered;
5. Level of functioning/competency 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.

5

NOJOS Level Five: Sex-Specific Group Home/ Independent Living / Sex-Specific Treatment

Client Profile

Youth appropriate for NOJOS Level Five out-of-home placement can present as similar in risk to Level Four youth in that their risk cannot be controlled in their current living environment; and/or the youth's parents and caregivers cannot, or will not, provide adequate supervision. However, in addition, these youth present with the need for more intensive therapy through interactions and interventions throughout their day in their social environment and/or may need increased supervision than what is typically provided in a traditional foster/proctor home or family home setting from primary caregivers. Additionally, some youth may present with significant impulsivity and deficits in executive functioning and other comorbid issues resulting in their inability to self-regulate and higher probability that they will engage in sexual and/or nonsexual acting out behaviors, and/or need behavioral modification or skill enhancement interventions that cannot be provided in their home environment AND/OR would be more effectively provided in a group daily-intervention setting (i.e. milieu-group-based - clinical intervention)

Because this Level of care contemplates a congregate setting where there are more than two or three youth placed together, careful attention should be given to the potential contagion and greater opportunities to sexually act out that these youth will experience. For youth with a lower level of risk, continued participation in school in the community may be determined as appropriate at this Level, whereas higher risk youth may require a group home setting where school is provided internally.[4] Decisions regarding the amount of community access should always be based on the youth's individual risk, needs and responsivity detailed in their sex-specific assessment and ongoing assessment of their treatment progress.

Overall, NOJOS Level Five youth present from *moderate and moderate-to-high risk* as assessed by nationally recognized risk-assessment tools. Because of the potential range of risk at this level of

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4 Currently the Utah State Department of Health has created a contract for a hybrid program called Residential Support Services for l*ow-to-moderate risk* youth to receive intensive short term treatment intervention, supports, and 24-hour supervision focused on assisting a youth to transition back to their home and function as a healthy involved and contributing member of the community. This setting provides structure for up to 8 youth in a home with intensive family coaching, additional supervision staff, and aftercare. Generally, youth in a residential support setting present with *low-to-moderate and moderate risk* and do not require being stepped down to a Level 4 family-based care setting before returning home. Further, this setting should not include step-down youth from higher Level treatment settings. For youth with a lower level of risk in this setting, continued participation in school in the community may be determined as appropriate, whereas higher risk youth may require a group home setting where school is provided internally. The primary differences between a NOJOS Level Four out-of-home placement (including family-based care) or Level 5 intensive residential support, and a NOJOS Level Five Sex-Specific Group Home is the congregate setting, intensity of therapy, increased opportunity for milieu (social environment) intervention and increased supervision.

care these youths' risk, needs and responsivity must be considered carefully to determine if this level is appropriate. Importantly, it is critical for sex-specific assessment evaluators to specifically document the reason(s) for the recommended removal to ensure that lower risk youth are not perceived at a higher risk due to the recommended removal to accommodate the competing needs of their sibling victim. Furthermore, the youth's vulnerability for contagion should also be documented to ensure this level of care is warranted.)

1. **Sex-Specific Group Home**

NOJOS Level Five Sex-Specific Group Home intervention provides targeted sex-specific treatment in a therapeutic group-home setting. The primary differences between a NOJOS Level Four out-of-home placement (including family-based care) or and a NOJOS Level Five Sex-Specific Group Home is the intensity of therapy, increased opportunity for milieu (social environment) interventions, and increased supervision. NOJOS Level Five programs provide a greater intensity and frequency of clinical services (including in the moment milieu interventions), and twenty-four hour (awake) supervision. Because the range of risk seen at this level can be elevated, higher risk youth may require in-house or "in-custody" academic services rather than attending school in the community, whereas more moderate risk youth may be able to safely participate in school in the community. Safety to the community takes precedent; however, ideally the more a youth can have less disruption and *safe* opportunities in the community to practice skills, the greater the likelihood of seamless transition home.

2. Independent Living

Some youth who have successfully completed a higher level of care, (such as a High risk Level Six or High risk Level Eight secure care, may need *a structured transition* either into Independent Living (for older adolescents without a family or kinship option), or home with family or kinship placement where they continue to be monitored and supported in a structured setting and receive targeted sex-specific treatment and wrap around services.[5]

3. Step-Up and Step Down Transitions

Some youth in lower level programs who are not progressing or demonstrate increased risk (or ongoing sexual acting out, greater aggression) may need to be moved up the NOJOS continuum to a higher level of care (as determined appropriate by an updated assessment of the youth's risk need and responsivity). Youth who are stepping down from a higher level of care should be carefully screened when blending with lower level youth to protect against potential contagion by the youth stepping down to less experienced, lower level risk youth. Overall, a group home setting is sometimes necessary to provide the youth more structured opportunities to practice,

[5] Wraparound services are a multifaceted, system-level intervention designed to keep youths with serious emotional and behavior disorders (SEBDs) at home and out of institutions whenever possible (Suter and Bruns 2006; Bruns et al. 2010; Winters and Metz 2009). As the name suggests, this process involves "wrapping" a comprehensive array of individualized services and support networks "around" young people in the community rather than forcing them to enroll in predetermined, inflexible treatment programs (National Wraparound Initiative Advisory Group 2003).

improve and generalize new competency skills. As noted earlier, Practitioners are encouraged to take steps to achieve an appropriate resolution in these cases where a conflict between these standards and legal and professional obligations occur.

Overall, 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. Additionally, 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 programs also provide a structured 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.

Differentiating Considerations For Out-of-Home Placements
Clinicians must observe special precautions when they select youth for a higher level of care as outlined below:

The client profile for youth placed in a Level Five Sex-Specific Group Home is similar to that of a NOJOS Level Four Out-of-Home Sex-Specific Treatment youth with some important distinctions. **Factors Level Four youth and higher level youth have in common often include deficits or issues in family functioning, home environment, and/or caregiver willingness and/or ability to provide proper supervision and/or the youth's regular participation in treatment** as follows:

1. Family 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 needed to address the youth's risk and/or treatment and/or supervision needs;
2. The adult caregivers are incapable of, or choose not to, provide the level of structure and supervision required to prevent sexual misconduct or assist the youth to deal with his/her treatment needs;
3. The family, through their own behaviors, values, and issues, do not provide a healthy environment for youth to heal and rehabilitate;
4. The family presents as enabling and/or denial-based mindset undermining the youth's responsivity to interventions or safety and well-being of victims in the home;
5. 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).

Factors that DIFFERENTIATE a Level Four, Level Five and Level Six youth include the following:

1. Level Six youth not only needs removal from their home environment due to

environmental and family risk factors, but also often present with greater frequency, duration of sexual problems, and/or sexual aggression as well as deficits in executive functioning, behavior management and/or antisocial characteristics;

2. Level Five and Level Six youth also often have social-competency issues and social relatedness issues and have difficulty in developing the skills necessary to be successful in the community, academic and/or home environments. These deficits require an out-of-home sex-specific group home setting and peer milieu to learn pro-socialization, proper boundaries, and healthy social skills. The group home setting is also necessary to provide the youth more structured opportunities to practice, improve and generalize new competency skills;
3. Similarly, Level Five and Level Six youth have difficulties with executive functioning that require a peer milieu/ social environmental interventions to develop self-insight, learn self- control and self-regulation.
4. Level Five youth are less-developmentally mature and under socialized than a higher risk Level Six youth requiring a sex-specific residential treatment center, (meaning a Level Five youth's developmental maturity level may place them at-risk for contagion and harm if placed in a Level Six program.);
5. Level Five youth present as more amenable or receptive to treatment than a Level Six youth;
6. Level Six youth present with greater problematic personality and temperament traits as indicated in the following:

    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);

7. History of, and/or current self-regulation and behavior-management issues in their home and/or school environment—unmanageability cannot be controlled in a less-structured environment. Higher supervision and/or a behavioral-management program is required;
8. Self-harm behaviors.

Factors Associated with the Onset, Continuation, and Cessation of Abusive Sexual Behavior and Nonsexual Offending Among Male and Female Adolescent Populations

The client descriptions referenced below were developed following a literature review of factors associated with the onset, continuation, and cessation of abusive sexual behavior and nonsexual offending among male and female adolescent populations. The descriptions are designed to assist clinicians, caseworkers, probation officers, forensic evaluators, the courts and other service providers and decision makers in: (1) identifying risk-relevant intervention needs; (2) prioritizing appropriate intervention strategies; (3) monitoring progress toward resolving identified needs; (4) facilitating case and/or treatment plan revisions according to current needs; and (5) evaluating the completion of interventions and readiness for discharge. Consistent with the Risk-Need-Responsivity (RNR) model, clients who have many intervention needs may require more intensive interventions that provide good support and supervision. Clients who have fewer intervention needs, may need more limited intervention or, perhaps even no interventions beyond what they have already experienced

Moderate and Moderate-to-High Risk	Moderate-to-High Risk and High Risk
Clients' understanding of appropriate sexual behavior is occasionally poor.	Client's understanding of appropriate sexual behavior is often poor.
Clients' understanding of the consequences of abusive sexual behavior is occasionally poor.	Client's understanding of the consequences of abusive sexual behavior is often poor.
The frequency of the client's sexual thoughts is occasionally unsuitable, and the thoughts preoccupy the client.	The frequency of the client's sexual thoughts is often unsuitable, and the thoughts preoccupy the client.
Client's sexual interests occasionally involve abusive sexual activities.	Client's sexual interests often involve abusive sexual activities.
Clients' attitudes and beliefs occasionally support abusive sexual behavior.	Client's attitudes and beliefs often support abusive sexual behavior.
Client occasionally manages sexual behavior inappropriately.	Clients often manage sexual behavior inappropriately.
Clients occasionally evidence a lack of compassion for others.	Client often evidences a lack of compassion for others.
Client's peer relationships are occasionally poor and/or involve social isolation.	Client's peer relationships are often poor and/or client is socially isolated.
Clients occasionally manage emotions appropriately.	Clients often manage emotions inappropriately.
Clients' social skills are occasionally poor.	Client's social skills are often poor.
Clients occasionally evidence poor self-confidence.	Clients often evidences poor self-confidence.
Client's lack of commitment to school and/or work is occasionally apparent.	Client's lack of commitment to school and/or work is often apparent.
Clients occasionally use unstructured time poorly.	Client often uses unstructured time poorly.

Client's attitudes and beliefs occasionally support socially inappropriate, rule-violating, and/or illegal nonsexual behavior.	Client's attitudes and beliefs often support socially inappropriate, rule-violating, and/or illegal nonsexual behavior.
Client occasionally manages nonsexual behavior inappropriately.	Client often manages nonsexual behavior inappropriately.
Client indicates occasionally having a negative relationship with a Primary Caregiver.	Client indicates often having a negative relationship with a Primary Caregiver.
Client indicates occasionally lacking a positive relationship with any supportive adult.	Client indicates often lacking a positive relationship with any supportive adults.
Family functioning is occasionally poor.	Family functioning is often poor.
Unsafe and/or unstable living conditions are occasionally experienced.	Unsafe and/or unstable living conditions are often experienced.
Client occasionally lacks involvement with community resources.	Client often lacks involvement with community resources.
Client's mental health concerns are occasionally managed poorly.	Client's mental health concerns are often managed poorly.
Client participation in interventions is occasionally poor.	Client participation in interventions is often poor.

[Youth Needs and Progress Scale Development Literature Review, 2020, page 5.]

Treatment Modalities

1. Sex-Specific Group Home

Overall, treatment objectives should be holistic and include specific goals, tasks, and methods to address the youth's sex-specific criminogenic factors, co-occurring mental health issues, and skills-development services. Treatment and programming at this Level should include targeted sex-specific treatment (individual, family, and group therapy at least weekly), competency and skills development services and traditional mental health counseling. Interventions at this Level should also include medication management services as deemed should also be appropriate.

Family therapy should include 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 dynamics.

As noted above, academic programming should be based on the youth's risk to the community and his/her educational needs as determined appropriate (i.e., may include Sex-Specific Day Treatment, Youth-In-Custody (YIC) classroom, Behavior Disorder (BD), private school, public school, etc.).

2. **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 rather than returning home or to a kinship placement. Sex-specific independent living programming should specifically assist these youth to integrate and generalize their newly acquired competency skills, and self-regulation skills, as they develop life 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, and the intensity of structure and therapy needed.** Overall, these programs are required to provide sex-specific treatment following the Good Lives Model and R-N-R treatment objectives with the modalities, goals and frequency outlined for *moderate risk* youth.

Monitoring

The sex-specific trained clinician and out-of-home caregivers and residential staff providing supervision, work together to monitor the youth's compliance in their living environment, school and in their sex-specific therapy. Youth who are Court ordered into State's custody will also be supervised by an assigned Department of Health and Human Services case manager who will coordinate with the treatment team and provide oversight of the youth's treatment progress and placement. Level Five youth will also need monitoring and support making forays into the community prior to being returned home. 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 and structured home visits.

The parent(s)/guardian(s)/supervisor(s)/tracker(s) may also provide supervision for the youth as deemed appropriate and approved by the NOJOS/ATSA sex-specific licensed clinician and Division case manager after being educated on the youth's individual risk and supervision needs and a family safety and supervision plan has been established. It is strongly recommended that information regarding appropriate supervision techniques (to be utilized with sexually traumatized youth, hyper-sexualized youth and youth who present a risk to engage in sexual misconduct) is included as part of the parent/guardian/ supervisor/tracker training. Further, The parent(s)/guardian(s) should be educated on the youth's risk and supervision needs and a family safety and supervision guideline plan prior to transition home.

Criteria for Discharge (See Treatment Process For Discharge Section above)

The length of treatment in a Level Five setting is based on the youth progress or lack of progress. Criteria for treatment progress include the accomplishment of all treatment goals and objections and demonstrating the implementation of desired skills and behavioral changes in observable behavior to reduce risk both individually and in family functioning and home environment. a Parent(s)/guardian(s) must also demonstrate they are able and willing to provide adequate supervision before the youth can be returned to their care.

Given the presumption of family reunification and treatment in least restrictive setting is paramount, networking and case coordination are essential to track the Level Five youth's treatment progress in a group home and prepare return home or discharge to a step-down placement. There should be consensus between the placing case manager and treatment team that the factors related to the need for out-of-home placement/treatment has been met and resolved to the point the youth and his home environment are stable enough and appropriate for the youth to step down to a lower level of supervision and intensity of treatment. If determined appropriate, a youth may complete treatment in with an outpatient Level Two sex-specific treatment provider. Lack of treatment progress may result in referral for more intensive treatment and/or supervision, which may also result in increased length of treatment. 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 and approved by the Court rather than solely based on client resistance and/or non-compliance.

These step-down and step-up alternatives are consistent with the Risk, Need and Responsivity NOJOS Continuum philosophy. Overall, treatment and placement decisions should always be made in accordance with the currently accepted Standard of Care and NOJOS protocols. Further, 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 to determine progress, increase in protective factors and reduction of risk.

Additional Discharge Considerations

Treatment professionals should be careful to coordinate the transfer of treatment services and keep parents adequately informed and involved. Further, 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.

As in any NOJOS 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 out-of-home youth undergo a discharge assessment to determine if:

1. Family issues and environmental risk factors have been stabilized and reduced (including assessment of the well-being and safety/readiness of a victim still residing in the home);
2. A stable support system has been developed;
3. Co-morbid issues have been addressed/stabilized/managed effectively;
4. Risk has been lowered;
5. Level of functioning/competency 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.

6

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.

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 his/her 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, social skills, and other competency skills training.

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. Theories of Sexual Offending, 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.*

7

NOJOS Level Seven: Inpatient Psychiatric Stabilization/ Sex-Specific Treatment Enhanced

Client Profile

Youth appropriate for Level Seven present with either acute psychiatric/mental health symptoms that require stabilization prior to final determination of their sexual risk, need and responsivity OR a chronic psychiatric disturbance that also includes sexual impulsivity, displays of unpredictable/uncharacteristic or pattern of bizarre/ritualistic sexualized behaviors, and/or unpredictable social behaviors that contribute to a *moderate-to high or high risk* to themselves, the community, and/or the safety of other youth in lower level programming.

IMPORTANTLY, it is only when a youth is presenting a CHRONIC or long term psychiatric condition that includes problematic sexual behavior, that their risk determination falls at this higher level on the NOJOS continuum. Youth with acute mental health issues (i.e. suicidality, depression, anxiety, etc.) may not necessarily be functioning at an upper NOJOS level of sexual risk but rather simply need stabilization of their comorbid symptoms prior to the determination of sex-specific treatment and supervision needs. Psychiatric symptoms can arise at any time throughout the assessment and treatment process.

Overall, these youth differ from Level Six and Level Eight youth based on their psychiatric disturbance. Their placement in Level Seven care is by their inability to manage their psychiatric symptoms and are therefore in need of Level Seven interventions and/or hospitalization or placement in an out-of-home structured psychiatric setting to stabilize these symptoms (either short term or long term).

Accordingly, assessment should clarify whether the youth presents with acute or chronic psychiatric symptoms, whether those symptoms override immediate need to focus on problematic sexual issues, and whether the sexual misconduct can be addressed as an adjunct, rather than primary, therapeutic intervention.

Treatment Focus and 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 problematic sexual 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 and reached the ability to respond effectively to treatment for the sexual issues. In most cases it is highly likely that once the youths psychiatric symptoms have stabilized, they may be able to be treated at a lower level and less restrictive level of care.

Importantly, most youth suffering from a psychiatric disturbance are too vulnerable to be placed with higher risk antisocial and conduct disordered youth and may also present too great of risk for vulnerable mentally ill patients who do not present with sexual behavior problems. This contagion consideration must be addressed specifically in their assessment to insure that the risk to themselves and/or the contagion risk they present to others is managed appropriately.

Youth hospitalized or placed in an out-of-home structured psychiatric setting, may or may not require sex-specific therapy upon stabilization and discharge. However, upon determination at discharge that the youth's risk and need require sex-specific intervention this should then be the primary focus in treatment. Treatment must continue to assess and manage problem behaviors (e.g., aggressiveness, impulsivity, or compulsive patterns of sexually assaultive behavior).

Treatment Modalities

Level Seven programs are typically locked, controlled-access units, either freestanding or part of a more controlled unit within a larger residential psychiatric campus, where the youth's activities and movements are controlled or monitored by staff on a twenty-four-hour basis. Level Seven programming includes 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 (See *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 the focus typically 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 at a minimum, if feasible, participate in regular sex-specific individual and family therapy that focuses on the youth's sex-specific behaviors and issues. Unlike Level Six youth, if the client population in the Level Seven facility 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 including group therapy.

Treatment Providers

Treatment providers should have expertise and experience in working with adolescents with acute and/or chronic psychiatric problems/issues as well as sex-specific expertise. Specifically, where at all possible, the sex-specific clinician providing therapy should have training and experience in understanding how psychiatric issues interplay with adolescent development and sexual development. The clinician who provides the therapy must be a NOJOS/ATSA or other nationally recognized specialty trained or certified sex-specific clinician. [See *Qualifications For Providers of Sex-Specific Assessment and Treatment section* above.]

Criteria For Discharge

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/symptoms are controlled/stabilized, the youth should be reassessed for an appropriate alternative NOJOS level of care/treatment or a non-sex-specific treatment program.

Treatment professionals in both the Level Seven and aftercare treatment setting should be careful to coordinate the transfer of treatment services and keep parent(s)/guardian(s) adequately informed and involved in all discharge plannings. If the youth has been adjudicated or is receiving supervision from the Juvenile Court and/or a State case manager, or Educational Consultant they should be involved in discharge and placement decisions as well.

Additionally, parent(s)/guardian(s) should be educated about, and demonstrate understanding, of the youth's mental health and sexually abusive behavior problems. They should also (with this understanding) demonstrate a willingness and ability to supervise their child if returned home. Transfer to a lower level of clinical intervention (e.g., sex-specific residential intensive, sex-specific group home, proctor/foster care, day treatment or home/outpatient) is usually necessary to maintain changes achieved by inpatient hospitalization. Aftercare services should provide the youth and family support.

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

1. Stabilization of the psychiatric symptoms and 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

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.

Discharge assessment required for a Level Seven youth should 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 or determine no longer applicable.

8

NOJOS Level Eight: Secure Care/ Correctional Sex-Specific Treatment Enhanced

Client Profile

Level Eight youth have displayed repetitious, predatory, fixated and/or violent patterns of sexual 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. Some of these youth often have a prior treatment history and have failed in previous less restrictive placements and intensive treatment settings (which may have resulted in additional legal charges). Overall, 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 and their limited amenability to supervision and less restrictive treatment alternatives.

Secure facilities are the most restrictive and highest NOJOS level of care. These facilities are the most securely confined settings provided for youth who commit repetitive sexual and/or non-sexual-assault behaviors. Secure facilities are for serious and habitually delinquent youth. They have high security and multiple barriers preventing escape.

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. It is strongly recommended that each youth complete an individually designed treatment plan based on their risk and rehabilitative needs, including where applicable court-ordered victim restitution as part of the requirements for release.

Youth In Care (YIC) academic 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. [See Secure Care Services]

Treatment Focus and Goals

Youth in locked correctional settings, present the greatest risk and need for intensive treatment intervention in order to rehabilitate and return to a more normative path of development. For those youth with adjudicated sexually abusive behaviors, sex-specific treatment is strongly recommended and should be based on the youth's individual needs and responsivity. (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).

The treatment goals for Level Eight should focus on increasing 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 competence and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home setting.

Treatment Modalities

Importantly, secure facilities should augment correctional programming with targeted sex-specific treatment modalities similar to a Level Six program including targeted sex-specific weekly individual therapy and group therapy to provide the youth with information regarding healthy sexual functioning and prevent further development of his/her sexual deviancy. Further, because family issues are typically a significant part of Level Eight youths' problems, it is strongly recommended (where possible) that family therapy be provided on a regular basis. With older adolescents, individuation issues should be addressed to assist the youth to grow toward young adulthood, emancipation, and eventually independent living.

Treatment should include sex education and healthy-sexuality work, life-skills training, social skills and relationship skills, and competency skill development training, and where applicable, 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 and social values and mores regarding sexual boundaries and healthy age-appropriate sexual conduct.

Given a higher percent of these youth present with histories of childhood abuse, neglect, exposure to sexual violence and disruptions in care givers, trauma-specific treatment is ***strongly recommended*** and should also be available for all youth who present with unresolved trauma Further, it is strongly recommended these youth have opportunities to resolve their own childhood victimization with sensory interventions *separate from* focus on their sexual offending to assist them to resolve their trauma, enhance emotional coping skills and the development and integration of a healthy sexual and prosocial identity.

Monitoring

Secure confinement provides maximum supervision of the highest risk 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 DJJYS), 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 (See Treatment Process For Discharge Section above)

As stated earlier, length of stay is typically determined by the guideline set by the youth parole authority based on clinical recommendation and the youth's sex-specific assessment following court order into secure care. Because of their elevated risk level and rehabilitative needs, most Level Eight youth spend many months in a secure facility. The treatment team including the State case manager monitor treatment progress and determine when the youth is eligible and can safely be recommended for release. The Youth Parole Authority must approve release.

Depending on risk potential and the youth's needs for structured/supported transition supervision, and continued treatment and skills building to ensure their safe and successful return to the community, the youth may need a step-down residential placement and/or outpatient treatment to ensure successful and safe return to the community. Based on research, following release from a residential secure level of care, many youth need additional support to be able to apply treatment gains and maintain new self-regulation and executive functioning skills in the community. Therefore, aftercare and follow-up treatment and transition support is strongly recommended following incarceration in a Level Eight Secure Care facility.

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