

*Wayne County
Comprehensive Approaches to Juvenile Sex Offender Management Initiative
(June, 2008)*

**Best Practice Guide: Best Practices in the Community-Based Treatment
of Juvenile Sex Offenders**

About Best Practices

Best practices refer to ideal and often, evidence-based practices, related to a variety of interventions and services that are based upon current research, accreditation standards, and various consortia of experts. *Best practices* guide practitioners and administrators to provide the most effective treatment and services and by doing so, assist all professionals involved in a system to improve and achieve stronger outcomes.

To specifically address needs related to juvenile sex offenders, *Best Practice Guides* have been developed in the four following areas: 1) Assessment, 2) Residential Treatment, 3) Community-Based Treatment, and 4) Community Supervision.

I. Community-Based Treatment for Juvenile Sex Offenders

Community-based treatment is often a critical component of juvenile sex offender treatment, allowing treatment to occur in a variety of community-based placements that might include the home, small group living, semi-independent living, or foster care. Specialized community-based treatment programs that are designed specifically for juvenile sex offenders to comprehensively address the specific issues related to juvenile sex offending (e.g., modus operandi, relapse prevention) and key treatment issues (e.g., family functioning, substance use) are essential to the successful treatment of juvenile sex offenders.

There are ten major areas of community-based treatment that include the following: 1) General Issues, 2) Operations, 3) Placement Decisions, 4) Intake & Orientation, 5) Assessment, 6) Treatment Planning, 7) Treatment & Clinical Program Components, 8) Clinical & Adjunctive Treatment Issues, 9) Documentation, and 10) Program Completion & Release Planning.

II. Guiding Factors of Community-Based Treatment for Juvenile Sex Offenders

- Juvenile sex offenders are a heterogeneous (i.e., diverse) group with varying degrees of treatment needs that fluctuate over time
- Juvenile sex offenders require sex offender specific treatment to address the unique factors related to juvenile sex offending behaviors
- Juvenile sex offenders require sex offender-specific treatment available in a continuum of care that includes community-based interventions as well as residential treatment options
- The degree of juvenile needs and risk should dictate intensity of treatment needs and specialized placement needs which at times will require residential treatment and at other times, community-based treatment

- Less serious juvenile sex offenders that can safely remain in the community should receive juvenile sex offender-specific community-based treatment
- Following residential treatment, community-based re-entry & aftercare programming plays a crucial role in sustaining successful treatment gains

II. Best Practice Areas in the Community-Based Treatment of Juvenile Sex Offenders

1) General Issues

- A continuum of community-based (C-B) treatment options must be offered as part of the region's sex offender management system including out-of-home & in home services, community-based treatment models that serve as initial treatment programs, and community-based re-entry/aftercare programs
- Juvenile sex offender-specific C-B aftercare/re-entry programming must be coordinated between residential & C-B providers to promote continuity of care, preventing redundancy in services and building on previous treatment gains (i.e., C-B treatment should not duplicate residential treatment for youth that have completed residential juvenile sex offender treatment)
- C-B treatment must be available for specialized populations (e.g., developmentally disabled or mentally ill youth, older teens/young adults) that focus specifically on their developmental or other specialized needs
- C-B programs for juvenile sex offenders must involve all relevant supports, including family, in the treatment process
- Out-of-home C-B placements (e.g., foster home, semi-independent living) should be located in close proximity to family and/or other supports of the youth
- Key administrators and community stakeholders (legislators, court officials, victim advocacy, CMO's) should be aware of all of the region's specialized C-B programs (i.e., full continuum) and receive information about the programs at least once annually
- C-B juvenile sex offender-specific treatment options should range from 10 – 12 months while re-entry/aftercare services (for juvenile sex offenders following residential treatment) should range from 6-10 months
- There is evidence of culturally-competent services and treatment in all relevant facets of community-based treatment (e.g., socioeconomic class, able-ness, gender)
- Articulated program philosophy and treatment model must be in place in all community-based programs
- All community-based treatment programs should adhere to an empirically-based common model/theoretical approach for juvenile sex offender treatment that is based on cognitive-behavioral and multi-systemic theories
- Regular program monitoring occurs to ensure adherence to best practice standards related to community-based treatment

2) Operations & Staffing

A. General Issues

- Staff working directly with juvenile sex offenders in community-based treatment programs are appropriately credentialed
- Clinical supervisors with appropriate credentials (Master's degree in Counseling, Psychology (clinical), Social Work (clinical) and relevant training and experience oversee clinical treatment
- Clinical staff provide guidance to adjunctive workers (e.g., case mgrs.) working with juvenile sex offenders
- All staff possess appropriate academic and experiential credentials to work with juvenile sex offenders
- A treatment team focus is used in treatment decision-making that includes relevant professionals (e.g., case mgr., jurist) and non-professionals (e.g., caregiver, community advocate)
- Regular & ongoing training is provided to staff to continuously promote current knowledge related to juvenile sex offender treatment
- All program staff are trained specifically in cognitive-behavioral theory and multi-systemic interventions

B. Specific Training

Community-based treatment providers should minimally receive training in the following areas:

- Incidence & prevalence of sexual victimization,
- impact of victimization,
- etiology & characteristics related to juvenile sex offending,
- modus operandi
- assessment and treatment of juvenile sex offenders,
- caregiver & other support involvement,
- collaboration in developing intervention responses to address violations or risk factors
- cognitive-behavioral theory & multi-systemic approaches
- reducing secondary trauma or burn-out

3) Placement Decisions

- Prosecutors, jurists & others involved in placement decision-making should be well-informed of the region's juvenile sex offender treatment continuum
- The pre-dispositional assessment activities should guide and direct treatment and placement decisions for juvenile sex offenders (e.g., standardized assessment of needs)

- Placement decision-making should include the following: risk & needs of the juvenile, access to victim(s), proximity to home/community, caregiver capacity & involvement, least restrictive placement relative to treatment needs
- Juvenile offenders that were not originally provided juvenile sex offender-specific treatment (but rather general offender treatment), can be subsequently identified and offered sex offender-specific C-B treatment
- Comprehensive and systematic data analysis related to juvenile sex offending should be used to continuously inform the region about treatment and placement options and needs
- Placement & treatment decisions are commensurate with juvenile sex offender risk and needs (e.g., higher risk offenders receive more intensive treatment)
- Placement decisions ensure placement of developmentally-similar youth (i.e., age, mental capacity)

4) Intake & Orientation

- Juveniles and their families/supports receive specific information re: Juvenile sex offender-specific treatment, limitations, risks and benefits, and provide assent and consent for treatment
- Orientation to the program is provided to juveniles and families/supports within the first 48 hours following intake into the program
- Juveniles & caregivers receive a program handbook outlining all aspects of the treatment program including expectations regarding treatment attendance and participation
- Information regarding what to expect with regard to continued legal involvement with the juvenile justice system are thoroughly explained to the juvenile and family/supports
- Client rights and client grievance procedures are thoroughly explained
- Comprehensive clinical assessments are conducted by C-B providers during the first month
- Waivers of confidentiality are used to ensure information sharing among relevant treatment providers
- Efforts are made and documented to motivate uninterested juveniles and/or their caregivers in treatment
- Discharge planning begins with identification of tentative placement timeframe & required treatment outcomes

5) Assessment

- All previous assessment reports should be gathered by the C-B treatment provider and used to provide baseline data & inform initial treatment planning
- Comprehensive clinical assessment practices should be conducted by all C-B treatment providers to direct treatment interventions and measure program outcomes
- Additional mental health evaluations should be conducted only when justified through prior assessment (e.g., neurological evaluation)

- All medical assessments (including psychiatric assessment & treatment) should be conducted by community-based providers available to youth regardless of program placement status (not affiliated with program) to ensure long-term continuity of services

Comprehensive pre-post assessment should be provided to assess treatment outcomes that minimally address the following:

- Juvenile Sex Offender Risk Offense (i.e., J-SOAP II)
- Mental Health
- Substance Use
- Functional Ability
- Family Functioning
- Independent Living Skill Development
- Youth Needs & Strengths

6) Treatment Planning

- Policies exist articulating the development of treatment plans (i.e., timeframes for development, required information, etc.)
- Both juveniles & caregivers are involved in the tx. planning process
- Multidisciplinary teams are involved in the tx. planning process (i.e., clinicians, case mgrs., other workers)
- Tx. plans directly stem from assessment data
- Tx. plans reflect the individual needs of the juvenile
- Tx. goals are observable and measurable
- Specific interventions are identified to facilitate goal attainment
- Target dates for goal attainment are identified
- Treatment plans are updated at least quarterly

7) Clinical and Treatment Program Components

A. General Issues Related to Clinical & Treatment Components

- A cognitive-behavioral approach is utilized
- Multi-systemic theory and multi-systemic interventions are utilized in all C-B programs, actively engaging all community supports in the treatment process (i.e., family, school, neighborhood, employer)
- Relapse prevention components are included in the comprehensive treatment program
- Parents/caregivers & other significant supports are included in the treatment process
- The composition of group therapy is based upon juvenile needs reflecting homogeneity (similarity: age range) of group membership to promote effective group work
- Group therapy is the primary modality provided
- Co-facilitators are used to facilitate group therapy
- Group size does not exceed 12 youth

- Family therapy and individual therapy are provided as adjunctive treatment modalities
- Treatment is always tailored to meet the unique needs of each juvenile (e.g., offense history, support network, developmental level)
- Treatment environments are supportive, structured, and respectfully challenging
- Specific clinical attention is given to the development of pro-social behaviors and continuous demonstration of such behaviors is continuously promoted
- Treatment is organized around specific and measurable treatment goals
- Only individuals that are invested in the treatment process are a part of the treatment process
- Community-based providers work diligently to engage several community supports in the treatment process as part of developing a community support network for each youth

8) Clinical & Adjunctive Treatment Issues

A. Specific Clinical Issues to be Addressed in Treatment

- Cognitive distortions
- Empathy
- Denial
- Healthy sexuality & sex education
- Interpersonal skills & relationships
- Social skills
- Self-esteem
- Values clarification
- Emotional regulation
- Behavioral regulation & mgmt.
- Deviant sexual arousal
- Balanced and restorative justice

B. Specific Adjunctive Treatment and Services to Be Provided in Community-Based Treatment

- Substance abuse treatment
- Mental health treatment
- Educational services
- Vocational services
- Parent support
- Parent education
- Independent living skill development
- Additional specific needs are addressed as needed (e.g., housing)

9) Best Practices in Community-Based Treatment of Juvenile Sex Offenders: Documentation

A. General Issues in Documentation

- Records maintenance and information sharing complies with state and federal confidentiality laws
- All staff receive adequate training in documentation and record-keeping

B. Specific Documentation Needs for Juvenile Sex Offender Records

- All prior assessment information (e.g., initial assessment summary) & records (e.g., victim reports, police reports)
- Informed consent
- Confidentiality waiver
- Treatment contract
- All prior & current treatment plans
- Progress notes
- Other agency reports
- Social service investigations
- Registration documentation (if applicable)

10) Best Practices in Community-Based Treatment of Juvenile Sex Offenders: Program Completion & Release Planning

A. Program Completion & Release Planning

- Community-based programs must have clearly delineated criteria indicating requirements for successful program completion and reasons for program termination (provider-initiated termination due to client non-compliance)
- Discharge/release planning is inclusive (involves all necessary stakeholders), structured, & begins at intake
- Multi-disciplinary teams are involved in release planning and in premature termination planning (i.e., outside efforts to prematurely end treatment)
- Treatment is not disrupted/youth are not removed prior to program completion without clear clinical justification & multi-disciplinary decision-making
- Open communication and ongoing collaboration in treatment planning occurs for all individuals involved in treatment planning & release decisions (e.g., jurist, case manager, clinician) to ensure collaborative decision-making
- Programs attempt every effort to assist youths in achieving success and utilize graduated interventions prior to making a decision to terminate a juvenile from the program as a result of treatment non-compliance
- Juveniles that are terminated prematurely are provided with alternative treatment options

B. Re-Entry/Aftercare Programs

- Re-Entry/Aftercare programs must work collaboratively with residential providers prior to discharge to promote comprehensive transition plans
- Re-Entry/Aftercare programs must tailor clinical treatment around juvenile sex offender needs at release from residential care, building on past treatment & reducing redundancy in treatment

- Re-Entry/Aftercare programs must focus on sustaining treatment gains & increasing community supports, not on repeating the same treatment completed in residential placement

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