

STANDARDS OF CARE FOR YOUTH IN SEX OFFENSE-SPECIFIC RESIDENTIAL PROGRAMS

NATIONAL OFFENSE-SPECIFIC RESIDENTIAL STANDARDS TASK FORCE

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National Offense-Specific Residential Standards Task Force

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BACKGROUND AND ACKNOWLEDGMENTS

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We also want to thank Dr. Penny Cuninggim for her help in producing the first draft document which allowed us to get started.

Without funds to hire a professional editor, we needed help in developing a coherent draft that integrated the various writing styles of the seven central members of the working standards group. Initially, that task fell to Euan Bear of the Safer Society Program, whose talents were donated to this project. The Safer Society Program also made it possible for us to disseminate the document for field review to all the residential programs comprising their residential data base. Our thanks go out to both Euan and to the Safer Society Program.

Responsibility for final editing fell to Sandy Spellman of New Jersey ATSA who volunteered to pull the document together prior to its public release. In addition, our thanks go to Jeffrey Tucker who provided invaluable additional final draft editing assistance. Last, we extend our thanks to Wilson Viar for his ever-present technical and other help offered throughout this project.

To each and all of you--our financial supporters, advisory board, readers, editors, and other colleagues--we extend our gratitude. We share with you the commitment to safe and effective residential treatment for youth. To the extent that the practices advanced in this document result in fewer victims, it will be your contributions, ideas and hard work that helped make that happen.

BACKGROUND AND HISTORY

Over the past five years, an increasing number of programs have begun offering sexually abusive youth either offense-specific residential treatment, or offense specific treatment within heterogeneous residential environments. During this time, reports of sexual, physical and verbal abuse in these programs have also increased significantly, thus creating concern about both program quality of care and safety for the staff and residents. Concomitantly, the consequences of treatment failures for both potential victims and sexually abusive youth have become more serious. Trapped in an abusive lifestyle, these youth who were considered high risk for future abusiveness, often faced both severe prison sentences without treatment access, and, in many instances, placement on public access and public notice sex offender registries.

In response to these realities, state licensing and funding agencies, offense specific treatment professionals in general and residential treatment providers in particular, called upon the experts in the professional community to help identify the standards of practice for working with this difficult and uniquely challenging population.

All these interested parties recognized a compelling need for coalescing, developing and refining the collective professional expertise of the field to create a model of best standards and practices for the treatment of youth with sexual behavior problems. Such collaboratively developed and agreed upon standards are correctly viewed as the key to maximizing positive treatment outcomes, reducing the number of victims, and protecting the community. Such standards provide the basic guidelines and template for the most effective, safest, and highest quality treatment for youth with sexual behavior problems.

In 1996, Dr. Steven Bengis and Dr. Penny Cuninggim drafted a set of working standards to organize and refine their program-development work with several Massachusetts treatment programs. Impressed by how effective these standards had been in improving efficacy and quality of treatment, the programs encouraged Drs. Bengis and Cuninggim to expand on their effort, and offered to provide the initial funding for the creation of a national standards project. Dr. Bengis contacted several respected colleagues with expertise in offense specific residential treatment. They contacted others, and a core working group of seven was created. In addition to Dr. Bengis, the task force included: Art Brown, Ph.D., from Utah; Rob Freeman-Longo, M.R.C., L.P.C, from Vermont; Bryon

Matsuda, M.A., from Utah; Jonathon Ross, M.A., from South Carolina; Ken Singer, L.C.S.W., from New Jersey; and, Jerry Thomas, M.Ed, from Tennessee. They met in a two-day formal work session for the first time in 1996 and defined the Task Force's mission: To develop offense-specific standards of practice for residential treatment programs, balancing a commitment to quality and safety with an understanding of the practical realities of administering these programs in a complex and multifaceted service delivery system.

The group agreed that ultimately treatment programs providing these services should be required to meet specific standards of practice. They decided, however, that a great deal of preliminary work was needed before they discussed whether to form an accrediting body themselves or to pursue the goal through other means. Instead, the early meetings produced the following decisions and objectives.

1. To seek out an advisory board comprised of the top professionals in the offense specific field to help guide the development of the standards work.
2. To maintain a small working group to maximize productivity.
3. To use current research and existing literature to guide the work whenever possible.
4. To format the document using several sections: A statement of the standard; a rationale for the standard; a definition of relevant terms; and, evaluative criteria by which to measure compliance with the standard.
5. To invite wide peer review of the major working drafts of the document prior to dissemination of the final product.
6. To seek approval from the field for the development of standards through a questionnaire and by conducting workshops at national conferences of the Association for the Treatment of Sexual Abusers (ATSA) and the National Adolescent Perpetration Network (NAPN).
7. To share the work during the development stages only with colleagues who were involved in similar standards development efforts at the state level.
8. To seek legal advice regarding standards creation, dissemination, and possible accreditation.
9. To explore the possibility of developing collaborative accreditation procedures through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Council on Accreditation (COA).
10. To make decisions based upon consensus.

Based on these decisions, the group began its work by reviewing the initial document created by Drs. Bengis and Cuninggim and by suggesting additional standards. Assignments on the development of individual standards were made according to interest and expertise. Drafts of the standards were reviewed prior to formal meetings and any and all positions were discussed until the Task Force members reached agreement.

When consensus was reached on the initial draft, the advisory board and additional readers were asked to review the document and give input. As anticipated, that input proved invaluable and resulted in a significant re-write of major sections of the document.

During this time, selected members approached Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Executive Director of the Council on Accreditation (COA) to explore the possibility of collaboration. On the basis of those discussions, the group decided that a collaborative accrediting venture would not be the most effective way to maintain the integrity of the Standards project. Subsequently, after incorporating comments from the field gathered through questionnaires, the group decided against becoming an accrediting body themselves. Although the group supported the concept of national accreditation, making it an operational reality would involve creating scoring systems, examples of implementation and extensive field testing. Rather, than incurring further delay, the group decided that subsequent to publication of the final document, they would work with state agencies and licensing authorities to encourage them to incorporate the Standards into their own oversight and licensing mandates.

By the Fall of 1998, the working group, now known as the National Sex Offense-Specific Residential Standards Task Force, had: 1) Presented initial drafts of the work at national ATSA and NAPN conferences; 2) Been through two document reviews by the advisory board; and, 3) Completed several internal revisions. The Task Force completed a final draft that was prepared for dissemination both over the Internet and by mail to the professional field for peer review. The document appeared on the Internet for 3 months. Reviewers were asked to complete a questionnaire regarding their views of the document. At a final meeting in February, 1999, the Task Force reviewed these comments and completed the final revision.

Finally, the Task Force requested and received a review of the glossary to the Standards by the Center for Sex Offender Management (CSOM). CSOM edited the glossary and made several helpful suggestions that were utilized. CSOM also developed a glossary for general multi-agency sex offender intervention that is complimentary to the Standards glossary. Additionally, CSOM reviewed the final draft of the Standards and made suggestions for revisions.

This final draft, completed and published in the fall of 1999, follows below. It is the hope of each Task Force member that this document will be useful to the field and provide motivation for the improvement of services to this population.

INTRODUCTION

These standards were written: 1) to increase program and professional accountability for sex abuse-specific residential treatment; 2) to provide residential service providers, placement personnel, licensing authorities, parents and other client advocates with a mechanism for evaluating the quality and appropriateness of sex abuse-specific residential programs; and 3) to establish a common baseline of safety and competence in abuse-specific residential care. The authors have worked to maintain programmatic quality and competence while supporting creativity and diversity and recognizing the broad differences among programs in physical site capacities, contracting requirements, licensing and oversight restrictions, and resource availability.

This document has been written for an adolescent population aged thirteen to seventeen years old. While many of the standards and evaluation measures may also apply to younger children and to adults, the document was written and reviewed with an adolescent population in mind. The document should not be used with younger or older populations.

Throughout the document, the evaluation measures allow for variances due to increased or decreased client risk levels. Therefore, the standards are as relevant to shelters and step-down group homes as they are to intensive residential treatment programs. These residential standards represent the best knowledge currently available in the sex abuse-specific field. Should future research and clinical experience alter the assumptions which form the foundation of this work, the authors plan to update the document to reflect this new information.

STANDARDS FORMAT

The twenty-eight standards that make up the body of the document are formatted to assist the reader in both interpretation and implementation. The standards are divided into the following four sections according to the primary areas covered:

Program Related Standards

Staff Related Standards

Residential Safety Standards

Clinical Intervention Standards

The following is a brief description of the format used:

STANDARD NUMBER AND TITLE

STANDARD:

The standard itself is a brief statement that embodies the overall purpose and target area of the standard.

RATIONALE:

The rationale provides more narrative to assist in developing an understanding of the background and intent of the standard.

EVALUATION MEASURES:

A list of evaluation measures is provided for each standard that gives more detailed guidelines for assessing compliance with, and implementing, the standards. This section is not meant to include all possible measures of compliance.

PROGRAM RELATED STANDARDS

Standards One through Seven are primarily related to overall program design.

1: COMMITMENT OF GOVERNING AUTHORITY

STANDARD:

The program's governing authority has knowledge of, and is committed to providing management and resources for quality implementation of an offense-specific program for sexually abusive/aggressive youth.

RATIONALE:

Any agency that accepts the responsibility of providing offense-specific treatment for sexually abusive/aggressive youth must understand, acknowledge and accept the seriousness of this work. Effective behavior management for, and treatment of, this population pose serious risk-management concerns. It is critical that those who are legally, functionally, and professionally responsible for the service providing agency give their informed consent to provide offense-specific treatment.

Even in carefully developed programs with the highest quality of management, there will always be some risk to other program residents, to the program staff, and to the community. The risk includes physical and sexual exploitation. The governing authority (Board of Directors, Corporate Officers, Advisory Boards) should know the risks and responsibilities inherent in the treatment of sexually abusive/ aggressive youth, and openly and willingly commit the agency to this endeavor by giving informed consent. Without such a commitment, the program may not receive the legal, functional and professional support needed for its development. The absence of such support could place the program and the community at serious risk.

EVALUATION MEASURES:

1. The program clearly describes in behavioral terms the youth population to be treated.
2. Members of the governing board and/or corporate officers receive sufficient information and training on sexual abuse dynamics and treatment to make an informed decision about committing the agency to work with this specific youth population.
3. Members of the governing board and/or corporate officers have signed an informed commitment to undertake the professional and risk-management responsibilities for treating sexually abusive/aggressive youth.
4. The agency has consulted an attorney knowledgeable about liability issues.
5. The governing board formally commits to supporting the program's mission and mandate to provide offense-specific treatment for sexually abusive/aggressive youth.

2: ADMISSION AND EXCLUSION CRITERIA

STANDARD:

The program's admission and exclusion criteria clearly identify the youth that the program can safely manage and effectively treat.

RATIONALE:

Treatment is safer and more effective when the program is designed specifically for the population to be served. Sub-populations of sexually abusive/ aggressive youth often have different needs in treatment methods, interventions, resources and materials. It is not effective, efficient, nor safe to treat a youth who meets the criteria for long-term secure residential placement in an outpatient group, nor to treat someone in a secure residential setting who could be effectively treated on an outpatient basis. Similarly, there are potential risks involved in the program utilizing a treatment model that is inappropriate to the psychological, emotional and behavioral characteristics of the residents being served.

To admit youth whose level of risk exceeds the program's established management and treatment capability, places the program residents, staff, and the general public at an unacceptable level of risk.

EVALUATION MEASURES:

1. The program has clearly written criteria identifying the characteristics and behaviors of youth who meet or do not meet admission criteria.
2. The admission criteria include, but are not limited to: gender, age range, profiles, level of risk to the community and other residents, cognitive capabilities, level of parental involvement, etc.
3. Assessment for admission is based on the best available data regarding the youth's behavior, history and background. The following information should be used to ascertain appropriateness for placement:
 - psychological evaluation within the past year;
 - evaluation of current mental health status;
 - offense-specific risk assessment;
 - police reports and victim statements;
 - psychosocial history;
 - psychosexual evaluation;
 - family psychosocial history;
 - educational records;
 - report of recent physical examination;
 - birth certificate;
 - documentation of legal custody;

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- documentation of funding source;
 - recommendation for residential treatment from referring therapist;
 - any other available assessments; and
 - collateral reports from other services involved.
4. The program conducts a personal interview prior to admission with the youth and his/her family. If this is not possible, the reasons are documented.
 5. The admissions committee requires the following information from the referral source to make an informed decision regarding acceptance:
 - a description of the youth's deficits and strengths from the perspective of the youth, family, and child placement agency, as well as other sources;
 - reports of previous interventions with the youth noting the outcome of each and the reason past interventions did/did not succeed;
 - family, school, behavioral, and other pertinent historical information;
 - any special condition that might influence the choice of placement or the need for more in-depth diagnostic work;
 - the goals and objectives expected of the placement;
 - the long-term permanency plan;
 - the services required to achieve the short- and long-term service plan objectives; and
 - the supports to be provided by the child placement agency and/or other agencies while the youth is in treatment.
 6. Programs, which do not require this information prior to admission, use a clear procedure for obtaining all available information within thirty days of the youth's admission to the program. During this thirty-day period, the program has clear policies and procedures for managing the risk associated with accepting that youth with less information.
 7. Admissions staff utilizes information about milieu mix to make decisions regarding new admissions. The treatment setting and the number of sexually abusive youth to be served are considered as well as the individual youth's:
 - concrete versus abstract reasoning ability;
 - age and developmental maturity;
 - violent versus nonviolent profile;
 - demonstrated paraphilias; and
 - any learning disabilities, level of traumatization, psychiatric diagnosis, addiction or other dual diagnosis issues.
 8. The program informs referral sources of admission decisions in a timely manner.
 9. The program documents the source and level of funding for the youth and indicates whether these resources allow sufficient time for the anticipated treatment needs.
 10. The program works closely with the resident, family and/or legal guardian and responsible agency to assist in a transition from care when funding is disrupted.

11. The program documents reasons for rejection and makes recommendations the most appropriate services.
12. When a program must admit a youth whose profile or treatment needs fall outside the established admission criteria, the program should create a specialized risk-management and/or treatment plan. When such youths are admitted, the program must routinely review the youth's progress and seek out alternative, more appropriate placements in a timely manner.

3: INTAKE AND INFORMED CONSENT

STANDARD:

The program has a clear offense-specific intake procedure that includes informed consent.

RATIONALE:

Intake, the process of admission or reception into a treatment program, is usually the first contact that a youth and his or her family will have with offense-specific treatment. It is an opportunity for program staff to inform all relevant parties of the benefit of participation in treatment, the consequences of non-participation, and the need, content and goals of treatment. Intake can serve as the beginning of a positive involvement in the treatment process or it can set the stage for distrust, hostility and resistance both for the youth and his/her family.

During intake, both the youth and his/her parents or legal guardian should be asked to sign an informed consent to confirm their understanding of the treatment program policies and procedures. An important part of this consent is the issue of confidentiality and the necessity for information sharing among systems and professionals who work with sexually abusive/ aggressive youth.

EVALUATION MEASURES:

1. The program follows a written intake procedure.
2. Whenever possible, the family is present during the intake process. If not physically present, family may be involved by phone or mail. During the intake process, the family receives clearly written information about the program which should include:
 - the rights of the family and the youth/resident;
 - treatment goals;
 - treatment interventions to be used and changes required for discharge;
 - the benefits and risks of treatment interventions;
 - conditions to be met prior to family visitation and/or youth's reconciliation with, and/or reintegration into, the family; and

- role of the family in supporting treatment, relapse prevention and maintaining the safety of younger siblings, victims, or potential victims in the household.
3. The program provides the youth, family and/or legal guardian with a written treatment agreement specifying their responsibilities and requiring their signatures.
 4. The intake file includes:
 - documentation of admission status (i.e., court ordered or voluntary) signed by those legally responsible for the youth;
 - releases of information;
 - resident and family's orientation to program's goals and modalities;
 - signed treatment agreement; and
 - any other information required by the laws of the jurisdiction or the ethics of the professionals.

4: LEAST RESTRICTIVE SETTING

STANDARD:

Each resident has the right to treatment in the least restrictive setting that maximizes resident and community safety.

RATIONALE:

Offense-specific residential treatment programs must provide for the rights of residents in a manner that does not conflict with the obligation to maximize community safety. The program should provide a continuum of services for sexually abusive/aggressive residents covering a range of treatment intensities and community access. Only residents who require severe restrictions in order to manage their level of risk to the community should be housed in restricted settings.

Offense-specific assessments should include recommendations regarding the environmental restrictions necessary to safely treat a resident, which may not always directly correlate with the severity of the youth's sexually abusive/aggressive behavior. When a sexually abusive/aggressive youth is referred for admission to a program with a level of restriction exceeding that needed to safely treat the youth, the program should indicate that a less restrictive treatment setting is more appropriate.

EVALUATION MEASURES:

1. The program's mission, description of services, and treatment philosophy indicate adherence to the ethical concept of utilizing the least restrictive treatment setting necessary to provide safe, effective treatment.

2. The program maintains a list of alternative treatment programs or has access to reputable referral services for youths who require referral to a more restrictive or less restrictive treatment setting.
3. The clinical records for each resident include written justification for the level of restriction in the treatment setting. This justification is reviewed with the same frequency as the individual treatment plan.
4. The program's policies require the treatment team to recommend transfer to a less restrictive treatment setting when the youth no longer requires the current level of restriction.

5: VICTIM RIGHTS, RESIDENT RIGHTS AND COMMUNITY SAFETY

STANDARD:

The program must resolve any conflicts between the individual rights of the resident, the rights of victims, and the protection of the community in a manner that is both legally and ethically sound.

RATIONALE:

Compliance with victim and resident rights requirements imposed by law, licensure, accreditation and/or widely accepted intervention philosophy is essential to the provision of effective and ethical treatment services. Offense-specific treatment programs, however, face unique challenges in the area of victim and resident rights because of the nature of certain interventions utilized in offense-specific treatment. An offense-specific program must provide for the individual rights of the residents it serves in a manner that does not conflict with the responsibility to maximize community safety, protect past victims from further harm, and yet still produce a positive treatment outcome.

For example, preventing contact with past or potential victims may require the staff to screen a resident's mail and/or phone calls. Minimizing sexual contact between residents may require visual or electronic monitoring of resident bedrooms. Utilizing a written victim apology letter in treatment may necessitate contact with a victim advocate. When these and similar monitoring activities and interventions are utilized, specific consideration should be given to any potential conflict that may occur with resident rights and/or victim rights. Where conflicts do exist, the program must actively and adequately resolve these conflicts in a manner that is both legally and ethically sound. The process of resolving any rights conflicts should include communication with licensing, accrediting and/ or legal agencies that have jurisdiction over these rights.

EVALUATION MEASURES:

1. The program has a written policy identifying any monitoring activities and/or interventions that may be in conflict with the individual rights of the resident and/or victim. The policy includes justification for each monitoring activity and intervention as it relates to the protection of past victims, potential victims, and/or the community at large.
2. The program maintains documentation of how conflicts are resolved between the resident's and/or victim's rights and the monitoring activities and interventions. The documentation reflects direct communication with any licensing, accrediting, legal and/or advocacy agencies where applicable.
3. Any decision to restrict resident rights that is not related to program-wide monitoring activities and/or interventions will be made on an individual basis by a multi-disciplinary team solely for the purpose of protecting past victims, potential victims, and/or the community at large.
4. The program's description of the treatment philosophy and services utilized demonstrates a clear and general understanding of, and sensitivity to, victims rights issues.

6: TREATMENT MODEL

STANDARD:

The program's central treatment model is multi-modal, multi-disciplinary and offense-specific.

RATIONALE:

In order to meet the diverse needs of sexually abusive/ aggressive youth, a program will have to include a wide range of modalities, utilize a variety of theoretical approaches, and be delivered by a competent and well-trained, multi-disciplinary team. Then, in order to provide differential diagnosis and treatment for individual residents, the program will need to identify, and consider the impact of, the modalities and theoretical techniques which apply to each resident.

Treatment for sexually abusive/aggressive youth should focus on teaching the skills and abilities necessary for the resident to develop self-control and to manage his/her sexual behavior. This work takes place in various modalities and is integrated into all program components, particularly the direct care interventions.

EVALUATION MEASURES:

1. The treatment model should include an offense-specific program designed to alter those characteristics that support, or are precursors of, offending behavior and should include methods for addressing:

- the development of coping mechanisms necessary to lead a non-offending lifestyle;
 - cognitive-behavioral problems related to sexually abusive behaviors;
 - relapse prevention;
 - deviant arousal, sexual interest, and/or inappropriate fantasies;
 - previous victimization history, including post traumatic stress disorder ;
 - sexual aggression;
 - development and demonstration of victim empathy;
 - the concept of restitution;
 - anger management, assertiveness, interpersonal and communication skills, and observing their implementation;
 - precursors to sexual abuse behavior such as the assault cycle, chain, or pattern that may be applied to other behavioral problems;
 - cognitive and educational capabilities;
 - family needs, issues, and dysfunction;
 - integration of the youth back into the community, school, and family;
 - positive and healthy sexuality; and
 - collateral clinical issues, (e.g., developmental issues, attachment disorders, etc.)
2. There are written assignments and activities that document the youth's movement through the program, including achievement of measurable goals and demonstration of skills. Resident's level of achievement may result in decreased/increased restrictions, supervision and/or privileges.
 3. There is a description of services that commits the program to providing specialized treatment to address sexually abusive/aggressive behavior. It is recommended that current research and practice in the field support this description of services.
 4. The program provides:
 - adequate time for internalizing knowledge in each area identified above;
 - written competency-based curricular materials in each area consistent with the cognitive level of the residents; and
 - appropriately trained staff to address each treatment model area (see Standards Four and Five).
 5. The requisite skills and abilities for program completion are objectively defined and measurable and outlined in the program description.
 6. The utilization of innovative approaches not supported by a significant body of research and literature is reviewed and approved by the treatment team and/or management.
 7. There are policies and procedures for each treatment modality and method. These are clearly descriptive and identify the multi-disciplinary team member responsible for its delivery.

7: RANGE OF CLINICAL SERVICES

STANDARD:

The program provides a range of clinical services that address both offense-specific and other clinical needs.

RATIONALE:

Sexually abusive/aggressive youth present with a wide range of clinical needs. Therefore, the clinical services provided by the program or through contracts with other agencies should include both general and offense-specific clinical options. Although general clinical services must not be the foundation of a program treating sexually abusive/aggressive youth, they are often essential to its support. For example, a seriously traumatized youth may begin focused work on trauma resolution prior to participating in an offense-specific group. Placing the youth in offense-specific clinical work as early as possible, however, should always be the goal.

All clinical services should be based on a thorough diagnostic assessment of both offense-specific and general clinical needs, as well as an assessment of the youth's ability to participate in various treatment modalities (e.g. group, individual, family, and/or experiential therapy).

EVALUATION MEASURES:

1. Each treatment plan describes the frequency and duration of all offense-specific clinical services to be provided to the individual resident.
2. The program provides each resident with the frequency and intensity of offense-specific clinical services consistent with the needs identified in his/her assessment and evaluation.
3. Each treatment plan identifies non-offense-specific clinical services to be provided to the resident. These services address areas of functioning that the assessment and evaluation have indicated as problem areas, such as psychological, biological, and intellectual.
4. The program maintains a written schedule that indicates the time, place, and staff responsible for all offense-specific clinical areas.
5. Clinical reports (e.g., quarterly updates, and discharge summaries) are written using offense-specific criteria to assess the youth's progress in every component of the treatment model.

STAFF RELATED STANDARDS

Standards Eight through Eleven are primarily related to program staff.

8: STAFF QUALIFICATIONS AND COMPETENCE

STANDARD:

The program employs staff who are qualified and competent to work with sexually abusive/aggressive youth.

RATIONALE:

The importance of the staff chosen to work with this population cannot be over emphasized. They are responsible for what the residents learn didactically, experientially, and through relationships. In addition, they provide the behavior management and control that establishes a safe and therapeutic milieu.

The importance of staff to treatment success makes it critical that the program establishes and uses recruitment, screening, hiring, and training guidelines that follow offense-specific standards of practice. Job descriptions should clearly identify the professional and personal qualifications necessary to work with this population and be specific about job responsibilities. Clearly written policies and procedures provide guidelines for supervision and evaluation of staff, as well as for scheduling staff so that the residents receive the supervision necessary to maximize safety and treatment impact.

A model that utilizes a strong, self-directed multi-disciplinary team will promote staff effectiveness and efficiency in providing consistent and competent delivery of services.

EVALUATION MEASURES:

1. The program has written guidelines for staff recruitment, which clearly state characteristics needed to work with this population. Established facilities, which develop offense-specific programs, inform current employees of the particular considerations of working with this population and the staff qualifications needed.
2. Trained interviewers knowledgeable about the personal and professional qualities needed for staff working with sexually abusive/aggressive youth conduct screening. Interviewers are alert for the personal and professional traits of applicants which characterize abusive personalities.
3. Applicants are required to disclose and undergo a search of records of criminal arrests and/or convictions, including a check of the child abuse registry if one exists in the state or states in which the applicant has lived.
4. Applicants are asked to disclose the nature of any criminal charges pending against them, including any civil or ethical complaints filed against them in their professional capacity.

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5. The program requires reports from three references that attest to the applicant's character, integrity, and ability to perform the task required for the position. One of these must be the current employer. As part of a complete and thorough reference check, standard questions are asked of each reference regarding the appropriateness of the applicant's conduct with clients and/or coworkers in past or current situations.
6. The program has written job descriptions for all staff members that cite professional and personal qualifications and experience, and identify job functions, responsibilities and competencies necessary to perform the job.
7. Written personnel policies and procedures are reviewed annually and include statements regarding:
 - staff qualifications;
 - benefits;
 - probationary periods;
 - performance evaluations;
 - continuing education requirements and opportunities;
 - promotions;
 - conditions of and procedures for dismissal and resignations;
 - orientation and training for new employees, and
 - established grievance procedures.
8. If applicable, professional staff meet the offense-specific licensure, certification, registration and renewal requirements of the state in which they reside or work.
9. Staff responsibilities, authority, channels of communications and supervisory relationships are delineated in written policies and procedures, a copy of which is given to every staff member. Updates and changes are added as necessary in a timely manner.
10. The multi-disciplinary team includes a mental health professional with a master's or doctoral degree from an accredited program of social work, psychology, education, counseling, or criminal justice, with a specialty in direct clinical practice and the necessary training to do offense-specific work.
11. The multi-disciplinary team has access to a psychiatrist with experience in the assessment and treatment of children and/or adolescents for the treatment of residents with psychiatric problems.

9: STAFF ORIENTATION AND TRAINING

STANDARD:

The program provides relevant offense-specific orientation and in-service training to all staff.

RATIONALE:

In order to assure the competent implementation of a safe, effective treatment program and therapeutic environment, all staff members must have offense-specific training. This includes anyone who has responsibility for the program or who will interact with the residents. Board members who may face community opposition to a program or who may be asked to support a program during a crisis must be adequately briefed about the nature and risks associated with treating this population. Senior administrators who are responsible for monitoring intake and discharge decisions, overseeing hiring and staffing procedures, and providing general support for the program must be knowledgeable in offense-specific safety, treatment, and intervention issues. Staff in all components of the program, must receive training commensurate with the level of expertise required by their job responsibilities. Staying current in an evolving field often requires access to community, state and national levels of expertise.

EVALUATION MEASURES:

1. The program implements a written plan for training all staff. This plan includes specific training topics for the governing authority, administration, and staff.
2. The program monitors each staff member to ensure completion of required training.
3. The program measures the internalization of essential training content at each staff level (e.g., pre- and post-test).
4. The program orients all new staff prior to their on-the-job contact with the residents. The orientation should include a basic offense-specific component as well as other job-specific information necessary to fulfill the duties of the position. These should be completed within thirty days of hiring.
5. The program completes training all new staff within six months of their start date.
6. It is recommended that the program have written policies and procedures providing annual release time for staff to attend local, state and national workshops and conferences in offense-specific work.
7. Newly hired staff work under the direct supervision of an experienced and trained staff person until they have reviewed individual treatment plans for the residents they are supervising and have completed an initial orientation period which includes training on offense-specific risk management and program policies and procedures.

8. The staff is trained in safe practices of working with residents with sexually abusive behaviors as well as working with mixed populations. When any staff are to be assigned to more than one population, they are trained to serve each population. Such training is documented either through the current program or through resume. With at-risk populations who contain a high percentage of sexual abuse victims, the staff is trained in specialized services for working with victims, particularly trauma resolution, and such training is documented either through the current agency or through resume, certificates and/or references.
9. The staff is informed of the potential emotional and psychological impact of working with this population prior to being hired or transferring to the program.

10: STAFF COMMUNICATION

STANDARD:

The program uses a comprehensive communication system with a multi-disciplinary team approach.

RATIONALE:

A communication system must be used to assure client safety, consistency in treatment, and the maintenance of a therapeutic milieu. For the highest quality of treatment and milieu-management, a continuous, cumulative, comprehensive, open and systematic sharing of information across all disciplines is required (e.g., communication logs; staff shift reports; resident charts; special treatment status for a particular resident, such as being on “close watch;” and treatment team staffing notes).

All staff need timely access to information regarding a resident’s behavior or demeanor that may impact on his/her safety, the safety of the staff, and the effectiveness of the treatment program. Verbal sharing of information by staff may be necessary due to time constraints during the day or at shift change. It is important, however, that information be documented in a staff-accessible communications log, and that the log be read and initialed both at the beginning and end of each shift, as well as during the shift whenever possible. Although treatment team decisions may not be immediately available in written format, the results should be noted in the communications log as soon as possible so all staff will be aware of decisions which may effect the resident.

EVALUATION MEASURES:

1. The program policies and procedures require interdisciplinary communication of relevant client information and describe how this information is disseminated.
2. A communications log is available to staff at all times and is secured from resident observation. This log has dated entries with signed time-notations by staff who read or enter comments.

3. The confidentiality requirements regarding the limits of sharing information across all components (e.g., individual therapy details) are clearly articulated.
4. The program uses forms and documents for specific information to be shared among its components.
5. The program requires and documents that representatives from each program component participate in meetings in which critical information is shared (e.g., planning, risk-level reduction, clinical staffing, discharge planning, etc.)

11: STAFF SUPERVISION

STANDARD:

The program provides regular offense-specific supervision for all staff working directly with residents.

RATIONALE:

As professionals in a specialized discipline that requires sophisticated skills, offense-specific treatment staff need close and regular supervision by qualified supervisors in order to address the personal and professional problems and issues of working with a sexually abusive/ aggressive population. In addition, supervisory staff need the opportunity to give direction and discuss performance issues with individual staff. There are unique stressors associated with working with sexually abusive youth (e.g. new fantasies, impulses, thoughts, feelings, urges and fears). Staff need the opportunity to discuss these issues in a safe, non-threatening, and supportive supervisory environment. In addition, supervisors need the opportunity to provide specific feedback and information regarding treatment interventions, techniques, and methods to staff.

EVALUATION MEASURES:

1. Written policies and procedures require periodic supervision of all staff to assure quality of staff performance, assign and monitor work, provide the basis for staff evaluations, and identify the need for additional training (see Standard Six).
2. Each supervisor documents the content of planned, scheduled supervision for all staff under his/her supervision.
3. The program's staffing pattern incorporates scheduled supervision time into the direct-care staffing patterns. The program maintains accurate records that reflect the delivery of required supervisory hours.

4. The program requires supervision to address both programmatic and personal or interpersonal problems that may result from working with this population and which may impact staff performance.
5. The program provides supervisory training to each supervisor. This includes training in methods of addressing personal and interpersonal issues in a non-intrusive and non-threatening manner.

RESIDENTIAL SAFETY STANDARDS

Standards Twelve through Seventeen are primarily related to maintaining resident safety.

12: FACILITY ENVIRONMENT

STANDARD:

The facility environment is designed or modified to address the management of offense-specific risks.

RATIONALE:

The physical site or facility environment has a significant impact on the delivery of safe offense-specific treatment. Although the physical site is not the sole determining factor, to some extent it will dictate the population that can be safely housed as well as the staffing ratio necessary for safe management. Not only must the physical site include sufficient space for housing this population; it must also provide the opportunity for private, personal hygiene.

If the physical site cannot be designed or modified to reduce foreseeable risk, then staffing patterns, programming, client management policies, and/or technological additions must be used to address design problems in order to reasonably moderate risk.

If the physical site does not allow for a self-contained offense-specific unit, then the program must be considered a mixed-population program and Standard Sixteen applies (see Standard Sixteen).

EVALUATION MEASURES:

1. The program has documentation describing how the physical site has been designed or adapted to safely manage the risk level of residents.
2. The program has identified physical site problems and has documented strategies to reasonably moderate risk.
3. The program assures that the site characteristics adequately address the risk level of the treatment population including potential risks to staff and/or residents (i.e., sexual/physical assaults, false allegations). These measures may include but are not limited to:
 - external restraints such as locked rooms, locked doors and fencing;
 - single rooms;
 - electronic monitoring;
 - clear lines of sight and minimal places to isolate;
 - windows within doors and “panic buttons”
 - sufficient physical space in all common areas and multi-person bedrooms to minimize physical contact;
 - sufficient bathrooms to allow for individual hygiene routines;
 - adequate recreational space for on-site recreational activities, and
 - staff-to-resident ratio appropriate for the risk level of residents.

4. It is recommended that a program which accepts high-risk youth and whose physical site adheres to only a limited number of the optimal site characteristics implement alternative safety procedures to compensate for these inadequacies, including but not limited to:
 - increased staff-to-resident ratios;
 - overnight awake staff capable of observing all residents during the night;
 - routines which minimize use of small spaces by residents, and
 - extensive electronic monitoring such as electronic bracelets, closed circuit visual and audio monitored crisis intervention rooms, and/or motion sensors.
5. The program policies clearly describe and document the risk-based criteria used for making and changing room assignments.

13: STAFFING LEVELS AND PATTERNS

STANDARD:

The program maintains a staff-to-resident ratio and pattern that provide adequate staff supervision.

RATIONALE:

Youth in residential treatment programs for sexually abusive behaviors can pose a significant risk both in the program and in the community at large. Particularly in the early phases of treatment, one can assume that whenever a sexually abusive youth is alone with another resident and/or out of sight of a staff member, that youth has access to potential victims.

Safe management of residents requires a staff-to-resident ratio adequate to provide the external control necessary to prevent sexual, physical, and emotional victimization. The risk level of the residents and the particular environment determines adequate staffing patterns. They provide direct visual supervision of all resident interactions and provide random and frequent visual supervision when residents are asleep.

The criteria for establishing adequate staffing ratio and patterns for should be developed by each program based on the acuity level of the residents, the skill and competency level of the staff, the intensity of the program, and the environmental structure. Once an adequate staffing pattern is determined, it should be maintained at all times - during transition, staff absences, vacations, and emergencies. Adequate staffing ratios are fluid, not static, and so they must be continually reviewed.

EVALUATION MEASURES:

1. The acuity level of residents, level of program intensity, physical layout of the program and the treatment needs of residents determine staff-to-resident ratio.

2. Staff directly supervises the residents at all times. There is always sufficient staff to ensure adequate treatment.
3. The program maintains a sufficient staff-to-resident ratio to ensure that no resident is alone with another resident, or out of sight of staff, at any time during his/her stay in the program. Exceptions are made in the case of overnight sleeping and/or a resident who has reached a level of privilege permitting time alone as part of his/her treatment plan.
4. Night staff is able to provide ongoing random and frequent visual supervision of residents consistent with the risk level of the treatment population.
5. Only staff members who at any given time are directly responsible for the visual supervision of residents should be counted in the staff-to-resident ratio.
6. The program follows written procedures for assuring that the staff-to-resident ratio is maintained at all times, including during staff absences for vacation, sickness, staff breaks, meals, shift changes, emergencies, community trips, van trips or any other program activity.

14: PREVENTION OF SEXUAL CONTACT

STANDARD:

The residential program prohibits and is designed to prevent any consensual or non-consensual sexual contact.

RATIONALE:

Establishing sexual safety, as well as physical and psychological safety, in the milieu is the highest priority in any treatment program and is actually the first intervention in treatment. Offense-specific residential treatment programs are designed to change those problems that are precursors to sexually abusive behavior. Youth come into treatment with sexualized behavior patterns and abusive interpersonal dynamics; therefore, programs should focus on preventing sexual acting out rather than merely responding to it. Sexual interactions between residents, whether consensual or non-consensual, cannot be tolerated in any treatment program.

Although developing age-appropriate consensual social and sexual relationships may be a goal for residents, even consensual sexual contact between residents is detrimental to treatment. It is counterproductive to the treatment needs of youth who are struggling to understand and manage sexual issues. While a goal of treatment for residents is to learn healthy sexual values, youth in a treatment program for sexually abusive behavior should never engage in sexual contact with each other.

EVALUATION MEASURES:

1. The program's policies and procedures indicate that sexual contact, whether consensual or coerced, between residents or between residents and staff is prohibited.
2. The program conducts personal safety training for all residents as part of mandated orientation shortly after admission. The curriculum is either a standardized prevention program or, if of a program-specific design, it must meet or exceed national standards of practice for prevention programs. The curriculum includes information about:
 - personal ownership of one's body;
 - policies and procedures about physical contact;
 - information about identifying, preventing and dealing with abusive situations;
 - procedures for reporting abuse; and
 - specific prevention and intervention strategies.
3. The program conducts personal safety training for all staff members prior to their working with this population. This includes information about:
 - the residents' personal safety program;
 - policies and procedures regarding physical contact;
 - reporting procedures;
 - guidelines for staff and resident interactions; and
 - environmental safety issues of the physical site.
4. Interviews with staff and reviews of their personnel records indicate they have received such training.
5. The program teaches and promotes healthy sexual values by requiring residents' participation in group or classes addressing these issues.

15: PROGRAM RESPONSE TO SEXUAL CONDUCT

STANDARD:

The program has a protocol for addressing sexual contact with/ between residents and/or residents and staff, and follows all state reporting requirements.

RATIONALE:

Instances of sexual contact and/or abuse (verbal, physical, or sexual) in a program are significant events which are counterproductive to the treatment needs of sexually abusive/ aggressive residents. Sexual contact between residents and staff whether during the resident's time in the program or after discharge is considered inappropriate, unethical and probably illegal. Sexual contact must be addressed immediately, regardless of whether sexual contact is non-consensual, which is illegal, or consensual, which is against licensing standards and program policy. There must be a consistent and formal mechanism for evaluating such instances, arriving at conclusions about the nature of the sexual contact, and implementing appropriate consequences, which might include removal of the resident from the program and/or criminal charges. Failure to respond to such incidents in this manner undermines the treatment integrity and safety of the staff and residents in the program.

EVALUATION MEASURES:

1. The program has a consistent and formal mechanism for evaluating accusations against a resident of engaging in sexual activity and/or sexual abuse of a staff member or another resident; arriving at conclusions about the nature of the sexual contact; and implementing appropriate consequences. These may include removing the youth from the program and/or criminal charges, if warranted. (Sexual abuse includes physical contact of a sexual nature as well as hands-off behavior such as voyeurism or exposure.)
2. Program policies and procedures prohibit sexual contact between staff and residents. Any reports of such conduct will be promptly and thoroughly evaluated and may result in prosecution of the staff member.
3. When allegations of sexual contact are reported between two residents and/or by a resident on staff, the program must report the allegations to the appropriate state authorities and/or follow program protocol for handling allegations of abuse/assault.
4. In every instance of sexual contact between residents in a program, between a resident and a community member, or between a resident and staff member, the program implements a written protocol for examining the incident retrospectively to identify and correct any policies which may have allowed such an incident to occur.
5. The program uses a written procedure for evaluating any and all accusations of sexual contact. This policy contains time lines for inquiry completion, requirements for written incident reports of involved/concerned parties, and methods for maintaining the safety of all involved individuals.
6. Interviews with staff indicate that the program adheres to this policy and supports staff members who wish to prosecute for any sexually abusive acts done to them by residents.

16: MIXED POPULATIONS

STANDARD:

A program with mixed treatment populations must demonstrate the ability to safely meet the treatment needs of all the residents.

RATIONALE:

Realistically, it often is not possible to separate sexually abusive residents from other populations, or even to separate sub-populations of sexually abusive residents. Efficiency, economics, and/or practicality often dictate that resources be shared. Sexually abusive/ aggressive youth are often housed, educated, and/or treated quite successfully in facilities with mixed populations. It is up to the program to ensure that treatment needs are met and that safety can be assured.

The decisions about when, where, and how to mix populations need to be made by a multi-disciplinary treatment team after careful consideration. Factors to be considered should include but not be limited to: the number of sexually abusive youth to be served; concrete versus abstract thinking ability; treatment setting; age/ maturity/ developmental factors; criminal behaviors; psychiatric or medical problems; intellectual capacity; and developmental or learning disabilities.

It is essential to meet the individual treatment and safety needs of residents of all populations. In general, sub-populations should not be mixed where age, behavior, intellectual functioning or developmental differences make it impossible to meet the clinical and safety needs of each youth.

EVALUATION MEASURES:

1. The program policies and procedures factor into the admission decision the safety of all populations. The resident's initial and ongoing assessment determines appropriate placement in a particular milieu, treatment track or unit.
2. The program documents the clinical justification for combining populations in a treatment setting.
3. The program follows a written description for each population that is served, where and how each is housed, and how interactions of populations are monitored.
4. The program implements policies and procedures for the physical environment to reduce the risk of sexual or physical abuse. The program requires that the environmental placement of individuals or groups is always a treatment team decision. Policies and procedures prohibit the placement of known sexual abuse victims who have not offended in the same bedroom with a youth known to have sexually abusive/aggressive behaviors. Policies and procedures require assessing the risk of victimization in all placement decisions.
5. Policies and procedures clearly define the limits of confidentiality in order to foster open communication among staff and administration and minimize the secrecy that enables any form of abuse.

6. The program follows clearly defined policies and procedures for the psychological, physical, and sexual safety of all populations.

17: RESIDENTIAL RISK MANAGEMENT

STANDARD:

The residential program mandates that offense-specific criteria be used for risk-management decisions.

RATIONALE:

It is necessary for residents to feel physically, sexually and psychologically safe in order for them to engage in and benefit from treatment. This is particularly true for youth who have been hurt and/or are hurtful in relationships, who have witnessed violence, and/ or who have experienced a pervasive sense of being unsafe and unprotected in the world in which they live. It is impossible for any change to take place when residents feel unsafe in the very place that is supposed to provide safety. It is also not possible for a program to attract and keep staff who are competent and consistent in their provision of services when they feel unsafe in the work place.

Comprehensive risk management requires that decisions regarding basic residential tasks and routines are determined according to offense-specific criteria and are based on providing the safest possible living environment.

EVALUATION MEASURES:

1. The program implements a written policy requiring the use of offense-specific risk-management criteria for decisions regarding:
 - room assignments;
 - hygiene routines;
 - level of direct staff supervision;
 - degree of access to the facility and to the community;
 - amount of family contact and level of supervision necessary; and
 - contact with any prior victim or perpetrator, specifying circumstances and level of supervision needed.
2. This policy describes how data will be collected to make risk-management decisions and identifies who will make these decisions.
3. Interviews with professional staff, documentation and observation indicate that these criteria are used on a regular basis.

CLINICAL INTERVENTION STANDARDS

Standards Eighteen through Twenty-eight are primarily related to clinical intervention strategies utilized by the program.

18: ASSESSMENT AND EVALUATION

STANDARD:

The program provides offense-specific assessment of, and evaluation for, each resident.

RATIONALE:

Although an offense-specific assessment and evaluation cannot determine guilt or innocence, it is essential to making informed placement and treatment decisions for sexually abusive/aggressive youth. The information obtained determines which interventions are most likely to affect the resident's problem issues.

A competent assessment and evaluation can provide critical information concerning a resident's risk of re-offending, his/her danger to the community, and the appropriate level of clinical intervention and supervision required. In addition, accurate identification of the social, familial, environmental, and behavioral treatment needs of the resident promotes appropriate and adequate treatment planning to achieve long term behavior maintenance. It is essential to identify any concurrent psychiatric diagnosis, as well as significant learning or medical problems that might complicate offense-specific treatment for some residents.

The usefulness of the assessment as a basis for risk management and treatment decisions depends on the adequacy and accuracy of the information and the competence of the evaluator.

EVALUATION MEASURES:

1. Prior to any assessment procedure, the resident and his/her family or guardian are always informed, verbally and in writing, of the purpose and procedures of the assessment, and of the role and expectations of the assessor. The resident and his/her family or guardian sign documentation acknowledging that they have been informed of and understand the assessment process.
2. The limits of confidentiality, including mandatory reporting laws, duty to warn, etc., are made clear to the youth and to his/her family or guardian prior to any assessment procedure. It is clearly articulated with whom the information and reports will be shared. The youth and family or guardian sign documentation acknowledging that these limits were explained to them and they understand them.
3. The methods utilized to gather information are empirically based or are considered accepted practice among offense-specific treatment specialists.
4. Mental health professionals with training and experience in offense-specific assessment conduct assessments. Qualifications include:
 - an advanced mental health degree in a recognized discipline;

- demonstrated experience evaluating sexually abusive youth and their families or direct supervision by someone who has that experience;
 - special training and demonstrated competency in offense-specific testing measures;
 - documentation of training in child abuse laws (e.g., reporting requirements) and the procedures for evaluating and investigating disclosures; and
 - compliance with any state certification or licensure requirements for performing offense-specific assessments.
5. A comprehensive risk assessment is conducted prior to each youth's admission to determine whether or not the program can provide adequate services and supervision for that individual. When such an assessment is not provided as part of the referral packet, the program either conducts the assessment or contracts with a trained offense-specific treatment provider to conduct the assessment prior to a treatment plan being developed.
6. The risk assessment includes collateral information such as:
- the victim's statement;
 - reports from the victim's therapist, when available;
 - juvenile justice reports;
 - psychiatric records;
 - information from previous placements; and
 - school reports.
- In addition, the assessor conducts a clinical interview. If available, the family is interviewed for information pertinent to decision making. The results of risk assessment instruments are not the sole criteria for decision-making.
7. Written risk assessment and evaluations include the youth's offense history and specific, detailed recommendations about the setting, intensity of intervention, and the level of supervision necessary for treatment.
8. Immediately after the youth's admission, the program conducts an assessment for treatment planning. This assessment is based on identification of specific problem areas, strengths and weaknesses, skills and knowledge, and identification of the precedents and antecedents of the sexually abusive behavior. The treatment planning assessment also includes consideration of thinking, affect, behavior, organicity or concurrent psychiatric disorders, family functioning, significant learning disabilities and/or medical problems.
9. The assessment for treatment planning includes:
- data collected for the risk assessment;
 - test batteries;
 - clinical interviews;
 - family assessment;
 - assessment of sexual arousal, social competence, and coping skills;
 - medical evaluation and mental status examination;
 - re-integration evaluation;
 - personality and intellectual functioning;

- sexual and deviant sexual history;
 - educational functioning; and
 - any collateral information.
10. Professionally recognized standards of ethical practice are followed in all assessments, including plethysmography or polygraphy.
11. Assessments also include staff notations of the resident's behavior. These should be documented in a timely and relevant manner and should include observations:
- in the community;
 - with peers, authority figures and family;
 - in school and social situations; and
 - in group, family and individual sessions.
12. The written evaluation includes:
- purpose of the evaluation;
 - history of presenting problem;
 - prognosis for treatment;
 - type of intervention and setting indicated;
 - recommendations for additional assessments or collateral information needed;
 - summary list of assessor's diagnostic impressions;
 - initial assessment of all known risk factors;
 - assessor's recommendations of the youth's appropriateness and need for offense-specific treatment;
 - recommended level of treatment;
 - an initial outline of offense-specific issues to be addressed in treatment; and
 - recommendations for any supplemental or adjunctive treatment deemed appropriate.

19: TREATMENT PLANNING

STANDARD:

The program uses comprehensive, offense-specific individual treatment plans for each resident.

RATIONALE:

Goal-oriented treatment plans that guide the process of treatment benefit everyone — the resident, his/her family, the treatment team, and the treatment program, as well as the funding and licensure agencies that seek program accountability. Treatment planning necessitates analytical and critical thought when defining problems and identifying the therapeutic interventions best suited for objective attainment of the treatment goals. It focuses the youth and the therapist on treatment outcomes.

A thorough treatment plan stipulates in writing what the relevant interventions will be, who will implement them and when, and how success will be measured. It provides clear objectives that promote the resident's understanding how he/she will achieve his/her goals. When the resident, family, and treatment team review this plan at regular intervals, it creates a benchmark of progress that everyone can understand. An effective treatment plan specifies measurable, behavioral outcomes.

Treatment plans for sexually abusive/aggressive youth should reflect not only the treatment issues identified for this particular population, but the unique diagnostic characteristics of the individual. There are collateral treatment issues that may be as important to preventing re-offending as the more generic offense-specific issues.

EVALUATION MEASURES:

1. The program implements a written initial individual treatment plan within 72 hours of a youth's admission to the program.
2. It is recommended that the comprehensive treatment plan be completed within 30 days. It is required within 45 days and must be based on the assessments.
3. The treatment plans are written using offense-specific terminology (e.g., precursors to abuse such as "grooming" patterns, chains or cycles, thinking errors, reduction of problematic arousal, fantasy management, relapse prevention, victimization issues, etc.) and specifies measurable behavioral outcomes.
4. The treatment plan is written in a manner that makes it understandable and useable in all program components by all staff.
5. The treatment plan is explained to the resident and parents or legal guardian and is signed by the treatment team, youth, and parents or legal guardian, when possible.

6. Review dates are established at a minimum of every 90 days.

20: USE OF INTRUSIVE METHODS

STANDARD:

Each resident has the right to be treated using the least intrusive methods necessary to achieve a positive treatment outcome.

RATIONALE:

Offense-specific treatment involves a wide range of methods, some of which may be considered intrusive. There is an absence of agreement in the field as to what actually constitutes an intrusive method. Any method that introduces a significantly unwanted element to treatment by involving atypical physical and/ or psychological intervention may be identified as intrusive. Special considerations should be given when utilizing techniques such as aversive conditioning, pharmacotherapy, targeting arousal, physiological assessment, and certain experiential treatment techniques that are considered intrusive. These and similar methods are generally utilized only after less intrusive methods have failed to be effective.

Offense-specific treatment programs face unique challenges in the area of resident rights and ethics because of the intrusive nature of some of the interventions that may be utilized and their potential impact on the individual resident. Programs should outline which intrusive methods they utilize and what safeguards are in place in order to protect the resident against unnecessary or inappropriate use of these methods.

EVALUATION MEASURES:

1. The program's mission, written description of services, and treatment philosophy adhere to the ethical concept of utilizing the least intrusive methods for achieving a positive treatment outcome.
2. The program implements written policies and procedures clearly outlining the following:
 - the type of intrusive methods used by the program;
 - conditions in which the methods are used;
 - criteria for determining which residents are included or excluded from these methods (e.g., all residents being subjected to polygraph or plethysmograph on a three month basis, only residents 16 and over will be assessed using the polygraph, etc.);
 - which methods will be considered voluntary, requiring informed consent on the part of the resident and any guardians and/or agencies responsible for the youth;
 - how informed consent will be obtained; and
 - how the effectiveness of the method will be assessed, documented and reviewed.

3. The program requires that the methods be individualized and used only after discussion and approval by the treatment team.
4. The program uses a written policy that defines those methods considered intrusive. The policy formally designates these methods as special treatment procedures, as outlined in the program's licensure and/or accreditation standards. This position statement will include references to research, professional publications, and/or practice guidelines that support or are relevant to the use of each method.

21: FAMILY INVOLVEMENT

STANDARD:

The program actively encourages and pursues family involvement throughout the treatment process.

RATIONALE:

For adolescents, the most influential and practical support system is the family. Therefore, it is important to make every attempt to involve the family in the treatment process. For many residents, family support will be a significant factor in treatment motivation and compliance. In addition, it is possible that family dynamics have supported or encouraged offending behavior. If a youth is to return to his/her home environment, these dynamics must be interrupted and alternatives that support non-offending behavior must be developed. And, finally, it is necessary that the family develops their own relapse prevention as well as support the youth's relapse prevention plan.

There are many other reasons for acknowledging the importance of family in one's life by taking a family approach to treatment. For example, some youth may need to grieve the loss of family or simply learn to use the family as a point of contact. In every case, residents should be taught the meaning of family and how to develop a healthy family support system that encourages non-offending behavior. If the cycle of victimization is to be broken, the resident must learn the skills to develop healthy family structures.

It is clear that a return to the family-of-origin may not always be possible or desirable. It is unrealistic to expect a youth to change or to maintain changes with a sabotaging or non-supportive family, particularly if he/she is to return to that family setting. For some residents, placement with relatives or foster families may be best. For others, group home or independent living may be necessary. It is the program's responsibility to develop the most appropriate, least restrictive placement for the youth and to work with those systems that provide familial support.

EVALUATION MEASURES:

1. Each resident's family situation is assessed at admission so as to make informed decisions concerning the family's participation in treatment. If the family is not able to participate in treatment, (e.g., because their rights have been terminated, because their inclusion in treatment would be counterproductive or because the family refuses to take part in the treatment process,) the reasons must be documented.
2. The family treatment program includes the opportunity for individual family therapy and offense-specific family education.
3. The program maintains regular contact with the resident's family and/or social support network.
4. The program provides or arranges for clinical staff qualified to work with the families of residents.
5. No contact is permitted between a resident and a former victim or sexual abuser until a thorough assessment has been completed. This assessment becomes part of the treatment plan. Based on offense-specific criteria, it must consider:
 - readiness of the resident to appropriately relate to his/her prior victim;
 - readiness of the resident to maintain safety in proximity to a prior perpetrator; and
 - assessment of the victim's readiness for contact, as determined by the victim's therapist or another clinician with expertise in treating sexual abuse victims.
6. There is an established time and space for family visits, which ensures privacy. Visitors have restricted access to the facility to protect confidentiality of other residents. Any non-family member permitted to visit should do so only when clinically indicated. All visitors must sign a confidentiality statement when visiting. If any family members who were victimized are visiting (with above considerations for safety), care should be taken that no other residents re-victimize or traumatize that victim through verbal, physical or other behaviors (e.g., intrusive stares, inappropriate comments or attempts to contact via letter or phone.)
7. The program follows a planned, systematic and documented protocol for reunification. This process considers the needs of the victim and the family and helps the resident and family achieve and maintain their optimal level of reconnection, ranging from full re-entry into the family to reconciliation without reunification, as well as all other forms of contact which might be beneficial.

22: PROGRAM MILIEU

STANDARD:

All treatment components must consider the offense-specific needs of residents and modify policies and procedures accordingly.

RATIONALE:

Safe milieu management and successful treatment of this population requires a comprehensive, open, continuous, cumulative, and systematic sharing of information across all disciplines (see Standard Ten). This means that all staff who interact with residents should be trained to use the same vocabulary/terminology regarding behavioral and treatment interventions to communicate with the residents and with each other. Staff should be knowledgeable in methods of integrating interventions across disciplines.

It is essential that staff, administration, and members of the governing authority understand that the special needs of sexually abusive/aggressive youth must be addressed 24 hours a day, 7 days a week. This means that the total environment of any residential program is offense-specific. The ways in which the residents interact daily with others, relate to authority figures, and deal with their feelings present opportunities for staff to address abusive dynamics in the context of daily living.

The program milieu provides an arena for living and growing, a new learning environment for experiencing and practicing non-abusive lifestyles.

EVALUATION MEASURES:

1. The program has clear documentation indicating the manner in which the milieu meets the offense-specific needs of the residents.
2. The program has modified its policies and procedures to consider the offense-specific needs of residents.

23: CASE MANAGEMENT

STANDARD:

The program provides offense-specific case management services.

RATIONALE:

Case managers are professionals trained in offense-specific treatment who communicate and/or collaborate with agencies and individuals outside the program in order to manage safe treatment, supervision, and aftercare. All interagency communications, planning for aftercare, and/or community support system interventions should be based on offense-specific criteria. For example, all participants in the resident's life with a need to know should be informed about his/her risk factors, treatment progress in the program, rationale for access to the community, and relapse prevention plan. Case managers are responsible for articulating these concerns competently

EVALUATION MEASURES:

1. Case management services are delivered by a designated professional and are provided according to offense-specific criteria.
2. The designated case manager is trained in offense-specific curricula (see Addendum A, for case managers.)
3. The program requires regular and ongoing contact with all external agencies involved with the youth's treatment, as well as with his/her family to provide them with updates on progress in treatment.
4. Case management duties include:
 - coordinating the resident's needs in the program such as phone calls, clothing requisition, medical appointments off-grounds, etc.;
 - serving on the treatment team, unless excluded for a valid reason;
 - coordinating communication between the components within the program and between the program and outside agencies involved with the resident; and
 - any other functions outlined by the program's job description for case manager.

24: MULTICULTURAL ISSUES

STANDARD:

The program has policies and procedures to address multicultural issues.

RATIONALE:

Programs serving youth from cultures other than the dominant culture should have an understanding of cultural issues reflected in the population and attempt to maintain a culturally diverse treatment staff.

Sensitivity to cultural differences is often essential for successful treatment outcomes. Cultures define gender roles differently, have various perspectives on masturbation, use different language to discuss sexual issues and/or do not use direct language at all (e.g., address such issues through the use of metaphor). The correct interpretation and understanding of culture-dependent body language is important to an accurate assessment of progress. Programs offering offense-specific services must be able to adapt their methods, language, and techniques to the realities of the diverse cultures from which the residents come and to which they will return, without sacrificing accountability, the internalization of self-control, or any other skills and techniques that will prevent further abusive behavior.

Cultural differences can be viewed as an additional tool and aid to communication and understanding rather than as an obstacle. Enlisting community elders or religious authorities in treatment and/or aftercare, for example, can contribute significantly to the success of treatment for residents from some cultures. Hiring culturally competent staff can help the program become more sensitive in its treatment philosophy and approach.

EVALUATION MEASURES:

1. The program implements a written policy that addresses the need for cultural sensitivity in the treatment of minority residents.
2. The program documents staff attendance at in-service or other training that addresses issues of multicultural treatment. This training does not have to be offense-specific.
3. The program documents ways by which the offense-specific treatment model has been made culturally sensitive.
4. The program provides multicultural training of all supervisory staff.

25: COMMUNITY REINTEGRATION

STANDARD:

The program develops and implements a systematic community reintegration plan for each resident.

RATIONALE:

It is much easier to teach residents to live in a structured and secure therapeutic environment than it is to teach them to transfer the skills they have learned in treatment to a community, family, school or work environment. As youth move through the treatment program, opportunities to practice newly acquired skills must be provided in realistic settings. This means that a resident makes gradual supervised reintegration according to his/her capabilities. Community reintegration is not simply a privilege for good work, it is a necessity and serves as part of the normalization process that allows the resident actually to apply what he or she is learning in treatment. Family reunification is part of the reintegration process, as is mainstreaming into schools, employment, unsupervised social contact, and all other community activities (e.g., field trips and excursions to movies, restaurants, and shopping).

All decisions related to community access and reintegration must take into consideration the rights, concerns and well being of known victims of the resident. The treatment team determines opportunities for increased freedom and responsibility based on their assessment of community risk.

EVALUATION MEASURES:

1. At admission, comprehensive community reintegration assessment is performed on all youth and their families to determine specific reintegration needs. Some individuals will have more significant needs for reintegration services and structure than will others.
2. The program develops and implements a reintegration plan for each resident identifying the step-by-step methods for systematic reintegration into his/her community, school, work, and/or family.
3. The treatment team, based on their assessment of the youth's risk to the community, recommends opportunities for increased responsibilities and decreased restrictions. These determinations are documented in the resident's file.
4. Only residents who have completed community reintegration training and activities will be recommended for discharge (as opposed to removal) from the program.
5. The program schedule provides planned, specific community reintegration opportunities for each resident to practice, in a real setting, the skills learned in treatment.
6. Programs that encourage and allow unsupervised social contact opportunities for residents with age appropriate partners in the community must:

- have written criteria to determine readiness for unsupervised social contact
 - have written policies and procedures for maximizing community safety during unsupervised social contact
 - document the resident's readiness for unsupervised social contact in their individual treatment plan
7. Programs must develop written policies and procedures regarding community access and reintegration that take into consideration the rights, concerns and well being of known victims of the resident (e.g., restitution activities, clarification sessions, mediation sessions, advising victims of resident presence in the community).

26: DISCHARGE CRITERIA

STANDARD:

The program has offense-specific, measurable and observable discharge criteria.

RATIONALE:

The resident, his/her family, and all professionals involved in the resident's case have a need and right to understand the criteria which will result in successful or unsuccessful discharge from the treatment program. Both types of discharge necessitate careful planning.

Criteria for successful program completion include accomplishment of specific treatment goals and objectives that are identified in the resident's individual treatment plan. Each goal of treatment is stated in measurable terms for just this reason. Successful completion of treatment must be based on accomplishment of specific measurable objectives, observable changes, and demonstrated ability to apply changes to current situations. Successful program completion requires multiple measures of change including behavioral, emotional, attitudinal, social, cognitive and psychological.

There should be evidence of increased victim empathy, a demonstrated ability to seek appropriate help when needed, and clear indications that the youth is able to manage his/her individual offense cycle, chain or pattern. In addition, the youth must have completed his/her treatment goals as outlined in the individual treatment plan, be competent in self-management of behavior, and have a written relapse prevention plan.

Unsuccessful or administrative discharge must be considered as carefully as successful discharge. Administrative discharge and referral to another program is appropriate when the treatment team determines that a youth has failed to meaningfully participate in treatment over a reasonable period of time, or he/she is unable to effectively utilize the treatment due to problems such as cognitive limitations, emotional instability or other factors beyond the youth's control. The guidelines for governing discharge for failure to meaningfully participate in treatment should be clearly established and shared with the youth and all other relevant parties prior to admission to the program. Continuing to treat youth who refuse to participate will, over time, undermine the progress of other residents.

EVALUATION MEASURES:

1. Discharge from the program is based on the accomplishment of offense-specific, measurable objectives, observable changes, and demonstrated ability to incorporate these changes in the community.
2. The program uses written policies and procedures outlining the competencies and/or criteria necessary to:
 - move to less restrictive components of the program;
 - make transition to more or less restrictive programs;
 - discharge for failure to meaningfully participate in or adjust to the program; and
 - successfully complete the program.
3. Upon admission, the program gives the youth and family or guardian written information regarding the competencies to be achieved in order to move to less restrictive settings.
4. The discharge planning process begins at admission with an assessment of disposition-related needs during the development of the comprehensive treatment plan. Discharge planning is integrated into the resident's treatment on a regular basis.
5. The youth and family or guardian participate in the discharge planning which is documented in his/her file.
6. In the case of possible discharge due to nonparticipation, the program provides the resident and family or guardian written notification(s) of deficiencies that are signed by the youth and family or guardian and placed on file. They detail:
 - steps needed to remedy the deficiency;
 - timeline for correction; and
 - statement of consequences of continued deficiency (ranging from reduction or removal of specific privileges and increases in supervision, to discharge from the program or the facility, along with any legal and/ or status ramifications).
7. The aftercare plan must be initiated before a youth is discharged from the program.

27: AFTERCARE SERVICES

STANDARD:

The program provides, arranges, or advocates for offense-specific aftercare services for each resident.

RATIONALE:

Research indicates that the post-discharge environment is a powerful factor in determining the successful long-term adjustment of youth who complete treatment programs. A youth returns to a world that lacks the controls, structure, treatment intervention and type of support to which he/she has become accustomed while in a program. Continued support and offense-specific treatment after program completion- aftercare- are critical if a youth is to maintain and apply the gains made in treatment.

Aftercare is a significant part of the treatment process. It encourages the youth to continue to use the tools he/she has acquired to prevent re-offending. It provides additional external monitoring and support for the youth after discharge.

Planning for aftercare begins at program admission, is an ongoing and essential part of all treatment planning, and involves all those critical to aftercare success - the treatment team, the resident, the family or support system, and all involved community agencies. The plan makes recommendations for the next level of care, treatment needs and considerations, educational or vocational needs, and other specialized services.

The services identified for aftercare are those that will assist the youth with the transition from a treatment environment to family, institution, or independent living.

EVALUATION MEASURES:

1. The program documents that aftercare planning was initiated on admission.
2. The program utilizes a clearly written and documented aftercare plan that includes:
 - family and/or positive adult and clinical support for relapse prevention;
 - arrangement of a risk-free or mitigated community living situation; and
 - a required, specific level of supervision.
3. The resident's file near discharge contains a signed aftercare plan identifying:
 - clinical support;
 - professional or group location and services;
 - positive adult or parent support/supervision person; and
 - healthy living objectives (adjunct services, living arrangements, supervision and necessary resources).

4. In developing and regularly updating the treatment plan, the program requires participation by the resident, family, or guardian, community support system, involved agencies and the treatment team.

28: EVALUATING TREATMENT EFFECTIVENESS

STANDARD:

The program evaluates the effectiveness of treatment for each resident.

RATIONALE:

Treatment programs should be held accountable for providing effective treatment. Programs should conduct outcome studies to assess the effectiveness of treatment services. Effective offense-specific treatment is indicated by measurable improvement in skills, understanding, attitudes and behaviors.

EVALUATION MEASURES:

1. The program has a discharge evaluation that will provide information about the resident's knowledge of the skills necessary to maintain a non-offending lifestyle.
2. It is recommended that the program incorporate a process for evaluating treatment effectiveness post-discharge.
3. All residents are tested on admission and on discharge with an instrument that measures criteria such as levels of denial, acceptance of responsibility for offenses, sexual education and attitudes, as well as other measurable factors.

ABOUT THE AUTHORS

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Arthur H. Brown, III, Ph.D., L.M.F.T., AAMFT Clinical Member and Approved Supervisor, is an independent consultant and trainer specializing in management and clinical treatment in residential juvenile sex offender treatment programming. In 1984 Dr. Brown began one of the first outpatient treatment programs for juvenile sex offenders with an OJJDP grant with the Utah Juvenile Court. In 1987 Dr. Brown started one of the first locked residential treatment programs for high-risk juvenile sex offenders in an acute psychiatric hospital setting. This program received Joint Commission Accreditation with Commendation (JCAHO) in 1993 and grew to be a 36 bed program. In 1988 Dr. Brown co-founded the Network On Juveniles Offending Sexually (NOJOS) which developed guidelines for treatment of sexually aggressive youth in a continuum of care for Utah. In 1993 NBC News with Garrick Utley and Betty Rollins recognized Dr. Brown as a national expert in residential treatment with sexually aggressive youth. Dr. Brown has consulted with numerous programs around the United States and has made numerous presentations at ATSA and NAPN in the past ten years. Currently Dr. Brown serves as the MFT Licensing Board Chairperson for the State of Utah and maintains a limited private practice in family therapy. Dr. Brown received his B.A. degree in philosophy from the College of William and Mary, 1966; an M. Div. degree in pastoral counseling from Duke University Divinity School in 1969, an AAMFT Approved Clinical Residency, Texas Medical Center, Houston, Texas 1970-71, and a Ph.D. in marriage and family therapy from Brigham Young University in 1976. Dr. Brown can be contacted at (801) 243-1085 or e-mail abrown@sisna.com.

Robert E. Freeman-Longo, M.R.C., L.P.C., is an independent consultant, educator, trainer, and author dedicated to sexual abuse prevention and treatment. Rob's focus is on public policy, public relations, and sexual abuse prevention and treatment. He is an international consultant in the field of sexual abuser assessment, treatment, and program development, and is co-founder and first President of the Association for the Treatment of Sexual Abusers. Rob was previously Director of the Safer Society Foundation, Inc. and the Safer Society Press from 1993 through 1998. He has published more than thirty articles and chapters in the field of sexual abuse treatment, and pioneered the Safer Society Press sexual abuser workbook series. Rob is the co-author of the books *Who Am I And Why Am I In Treatment?*, *Why Did I Do It Again?*, *How Can I Stop?*, *Empathy & Compassionate Action*, *Men & Anger: Understanding and Managing Your Anger for a Much Better Life*, *Sexual Abuse In America: Epidemic of the 21st Century*, and he has co-authored the Safer Society's *Nationwide Surveys of Sex Offender Treatment Programs & Models* since 1992. He is also co-presenter on the Safer Society Press videos *Relapse Prevention For Sex Offenders* and *A Structured Approach To Preventing Relapse: A Guide For Sex Offenders*. Rob has specialized in the sexual abuse field and has worked with victims, and with juvenile and adult sex abusers in residential hospital, prison, and community-based settings since 1978. Mr. Freeman-Longo may be contacted at (802) 273-3054 or e-mail robsaperi@aol.com.

Bryon Matsuda, M.Ed. has intended to provide and facilitate effective and meaningful services for troubled youth and families for the past 25 years. His work have been centered in Utah's Juvenile Justice System serving in different "on line" and "administrative" roles in the state's Juvenile Court Probation's and Youth Corrections' services. Currently he administrates Youth Corrections in Central Eastern Utah by directing a 24-bed multi use facility and the District's Case Management. He continues to strive to implement systematic and meaningful individual and comprehensive services. In 1987, Bryon co founded the Utah Network On Juveniles Offending Sexually (NOJOS) and chaired and co chaired the organization for the next 10 years. Bryon lead and facilitated the NOJOS vision of a statewide comprehensive continuum of services and care for juveniles offending sexually. Through many individuals and collective efforts Utah now has the beginnings of an eight level system of juvenile sex offense specific supervision and treatment services. Utah now has proposed standards and protocols of services for the state's different agencies' professionals from law enforcement, protective services, prosecution, probation, education, assessment and treatment. Bryon has keynoted 2 National Adolescent Perpetrator Conferences speaking to the process of building therapeutic delivery systems. He also educates juvenile probation services regarding sex offense specific intake and probation supervision. He has assisted Utah's program quality improvement by developing and implementing a program evaluation tool and process for juvenile sex offender specific residential programs. Bryon assists juvenile justice agencies and networking organizations throughout the United States with consultation services.

Jonathan E. Ross, M.A. is currently the Vice President of Performance Improvement for Alternative Behavioral Services which operates a continuum of treatment settings for juvenile sexual offenders including *The Pines Residential Treatment Center*. He was previously the Vice President of Clinical Programming at New Hope Treatment Centers where he developed the *Waypoint Program* that was featured on the nationally simulcast television documentary entitled *Scared Silent: Exposing and Ending Child Abuse* narrated by Oprah Winfrey. Mr. Ross has provided training or consultation for more than 350 agencies in 48 different states, provinces and territories in five different countries. He began providing specialized services to sexual offenders in 1979 when he co-founded the first comprehensive outpatient treatment program in New England to specialize in the evaluation and treatment of sexual offenders and victims of sexual abuse. In 1987, Mr. Ross was appointed to the *National Task Force on Juvenile Sex Offending* sponsored by the C. Henry Kempe National Center for the Prevention of Child Abuse and Neglect. Mr. Ross has published *Safety Considerations in Developing and Adolescent Sex Offender Program in Residential Treatment*, a chapter on interviewing techniques and risk assessment in *Juvenile Sexual Offending: Causes, Consequences and Correction*, the *Risk Assessment/Interviewing Protocol for Adolescent Sex Offenders*, the *Psychoeducational Curriculum for the Adolescent Sex Offenders*, and the *Correctional Sex Offender Treatment Program Guidelines*. Mr. Ross received both his Bachelor and Master of Arts degree in psychology from Connecticut College where he graduated Magna Cum Laude with Distinction in Psychology. He is an elected member of Phi Beta Kappa and recipient of the Connecticut College Department of Psychology Award for Excellence. Mr. Ross has received numerous honors and awards from professional organizations and networks for his work in treating sexual aggression. Mr. Ross may be contacted at (757) 459-5454 or e-mail at jer@jross.com.

Ken Singer, M.S.W., Licensed Clinical Social Worker, has specialized in the sexual abuse field since 1978 when he developed a multi-disciplinary team to deal with child sexual abuse in Mercer County, New Jersey. In 1984, he was asked to set up New Jersey's first residential treatment program for juvenile sex offenders. Several years later, he was invited to participate with the National Task Force on Juvenile Sexual Offending which produced several reports on recommended practice with this population. Mr. Singer maintains a private practice in Lambertville, New Jersey where he provides treatment for juvenile and adult sexual abusers, male survivors of sexual abuse, and couples with relationship and/or sexual difficulties. He co-leads a group for men on probation for sexual offenses in Trenton, New Jersey and has run groups for men involved with domestic violence. He is a trainer and program consultant in the sexual abuse field and is on the board of the National Organization on Male Sexual Victimization (NOMSV), the New Jersey Chapter of the Association for the Treatment of Sexual Abusers (ATSA) and the New Jersey Chapter of Child Assault Prevention (CAP). Mr. Singer has presented workshops at numerous conferences around the United States regarding sexual abusers and male victimization issues for over 20 years. Mr. Singer may be contacted at (609) 397-2760 or e-mail ksinger@njcc.com.

Jerry Thomas, M.Ed., President of J. Thomas Consulting and Training Services, has been an advocate for youth at risk for over twenty-five years. In the early 1980's she began focussing exclusively on the treatment of sexually abused and abusive youth. She has worked with these youth and their families as an individual, family, and group therapist, and as a program administrator. As her experience, expertise, and reputation in the field grew, Mrs. Thomas was invited to design, develop, and implement offense specific programs for sexually abusive youth. In 1990 she became an independent consultant, and founded J. Thomas Consulting & Training Services. In the last eight years J.T.C. & C.S. has provided a broad continuum of state-of-the-art consulting, training, and program design services to organizations and professionals who work with sexually abusive youth throughout the United States and Great Britain. Mrs. Thomas has worked throughout her career on behalf of numerous local, state and national professional organizations. She was a founding member and former Board President of the Memphis Child Advocacy Center, and was appointed to the Tennessee Task Force on Child Sexual Abuse, and the National Task Force on Juvenile Sexual Offending. Mrs. Thomas may be contacted at (901) 276-5741 or e-mail wilson@memphisonline.com.

Glossary Of Terms Necessary To Understand And Apply The Standards Used In The Treatment And Management Of Sexually Abusive Youth

Abstinence: The decision to refrain from taking part in a self-prohibited behavior. For sexual abusers, abstinence is the avoidance of fantasies, thoughts, materials, and behaviors that are associated with their offense patterns.

Abstinence violation effect (AVE): A term used to describe a variety of changes in beliefs and behaviors that can result from engaging in a lapse. Among the components of the AVE are a sense that treatment was a failure; a belief that the lapse is a result of being weak-willed and unable to create personal change; a failure to anticipate that lapses will occur; and recalling only the positive aspects of the abusive behavior (also referred to as the problem of immediate gratification). When sexually abusive youths are not prepared to cope with the AVE, the likelihood of relapse increases. The AVE is experienced most strongly when clients believe that lapses should never occur.

Abuse-specific: The treatment issues essential to developing internalized self-control to prevent re-engaging in sexually abusive behavior. Issues include the assault pattern, chain or cycle; cognitive distortions; reduction of inappropriate arousal; history of victimization or trauma; relapse prevention; and interpersonal and socialization skill development (e.g., anger management, assertiveness, stress management, communication skills, and appropriate interpersonal interactions) as related to abuser issues.

Abuse-specific case management: Case management services provided by a professional trained in abuser-specific treatment who can convey information to all other members of the interagency/ interdisciplinary treatment team and to the youth's family using abuser-specific terminology and treatment criteria.

Access to the community: A youth's ability to leave the physical confines of the program (with or without permission) and enter the community for any purpose with or without supervision.

Access to potential victims: Whenever a sexually abusive resident is alone with another resident or other vulnerable individuals in the program or community out of sight of a staff member.

Acuity level: The ability of the youth to comprehend and apply the information provided to him.

Admission and exclusion criteria: The specific characteristics of youth and level of risk accepted into the program or excluded as beyond the capacity of the program to treat and manage effectively and safely.

Adolescent/juvenile sexual abuser: A person who, legally or legislatively, is defined by the criminal or juvenile code as having a history of sexually abusing other persons.

Aftercare: The portion of treatment that occurs after formal termination or graduation from the primary treatment program and is provided either by the treatment program or by community resources planned and/or contracted by the treatment program.

Aftercare plan: The plan created by the primary treatment staff, family, other support systems, and the youth which includes the development of daily living skills; community reintegration while residing in a less structured/restrictive environment; relapse prevention; healthy living and competency building; and an identified support system.

Appropriate data: Police reports, victim statements, juvenile court records; case staffings; educational reports; psycho-social reports, including psychological testing such as WISC-R and other appropriate evaluations; abuser-specific assessments; psychiatric reports; prior therapy reports, etc.

Assault cycle: An abuser's pattern of assault that includes triggers, thinking errors, planning, etc.

Assessment: The process of collecting and analyzing information about a sexually abusive youth so that appropriate decisions can be made regarding sentencing, supervision, and treatment. An assessment does not and cannot determine guilt or innocence and it cannot be used to determine whether an individual fits the profile of an offender who will commit future offenses

Assessment capability: The program's or contracted provider's ability to identify the client's risk factors concerning potential harm to the community; validate charges; address the client's (and/or family's) denial; identify the potential risk for re-abusing according to current knowledge; make a determination of the nature, extent, and seriousness of the youth's sexual aggression; evaluate the youth's social, familial, environmental and behavioral treatment needs; specify recommendations regarding the ideal course of intervention and treatment, noting any concurrent psychiatric diagnosis and its impact on treatment and level of intervention; and indicate significant learning or medical problems and their impact on treatment and level of intervention.

At all times: Staff-to-youth ratio maintained during times of transition, staff absence, vacations, when youth are physically restrained as a consequence for unacceptable actions, during field trips, van trips and in emergencies.

Aversive conditioning: A behavioral technique designed to reduce deviant sexual arousal by exposing the client to a stimulus which arouses him/her and then introducing an unpleasant smell or touch.

Clinical Polygraph: A diagnostic tool designed to assist in the treatment and supervision of sexually abusive youths by detecting deception or verifying truth of statements by persons under supervision or treatment. There are three clear and testable issues relating to different time frames. - *Disclosure Test Sexual History* refers to the lifetime of the subject prior to the date of conviction, excluding the offense(s) resulting in conviction or court supervision.

- *Disclosure Test Instant Offense* refers to the offense(s) resulting in conviction or court supervision.
- *Maintenance/Monitoring Test* refers to the time period from date of conviction (once court supervision began) to present.

Clinical Support: Aftercare group or individual therapeutic support.

Cognition: Refers to the mental processes such as thinking, visualizing, and memory functions that are created over time based on experience, value development and education.

Cognitive Distortion (CD): A thinking error or irrational thought that sexually abusive youth use to justify their behavior.

Cognitive Restructuring: A treatment technique in which the client is made aware of distorted thinking styles and attitudes that support sexual offending and is encouraged to change these cognitions through confrontation and rebuttal.

Collaboration: A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. This type of relationship developed between supervising officers, treatment providers, polygraph examiners, victim advocates, prosecution and the defense bar has been credited with the success of effective sexually abusive youth management. This type of relationship includes a commitment to:

- Mutual relationships and goals;
- A jointly developed structure and shared responsibility;
- Mutual authority and accountability; and
- Sharing of resources and rewards

Collateral Contacts: The sharing and use of information regarding a sexually abusive youth among law enforcement, probation/parole officers, treatment providers, employers, family members, and friends of the offender to enhance the effectiveness and quality of community supervision.

Community: The environment in which people live, work and play that is not the residential treatment environment and features reduced or nonexistent officially imposed structure and supervision with increased opportunities for independent decision-making along with direct experience of consequences for the post-discharge client. The community is the home of potential — and possibly past — sexual abuse victims and perpetrators.

Community Notification Laws: Laws which allow or mandate that law enforcement, criminal justice, or corrections agencies give citizens access to relevant information about certain convicted sexually abusive youths living in their communities.

Community Supervision: Day-to-day casework by a supervision officer that centers around the officer's monitoring of the offender's compliance to conditions of supervision, as well as the offender's relationship and/or status with his/her family, employers, friends and treatment provider. Types of community supervision include:

Bond supervision (also called Pre-Trial Supervision): Supervision of an accused person who has been taken into custody and is allowed to be free with conditions of release before and during formal trial proceedings.

Parole supervision: The monitoring of parolee's compliance with the conditions of his/her parole.

Probation supervision: The monitoring of the probationer's compliance with the conditions of probation (community supervision) and providing of services to offenders to promote law abiding behavior.

Community safety: The protection of past, present and/or potential victims from the behavior of sexually abusive youth. The youth in care is regarded as a member of the community whose safety must also be protected.

Conditions of Community Supervision: Requirements prescribed by the court as part of the sentence to assist the sexually abusive youth to lead a law-abiding life. Failure to observe these rules may lead to a revocation of community supervision or to graduated sanctions by the court.

Consensual: In a sexual situation, both parties must fully understand the nature and ramifications of the act, and have the right to stop the activity.

Consistent with the next level of care: The competencies required for successful completion of the program based on assessment of the level of external control available in the youth's next placement site and the level of internalized self-control required by the youth to prevent him from engaging in sexually abusive acts or use of inappropriate aggressive or intimidation behaviors.

Contact: As a special condition of supervision or as a treatment rule, a sexual abuser is typically prohibited from contact with his/her victim or potential victims. Contact includes:

- Actual physical touching
- Association or relationship: taking any action which furthers a relationship with a minor, such as writing letters, sending messages, buying presents, etc.
- Communication in any form is contact. This includes verbal communication, such as talking, and/or written communication such as letters. This also includes non-verbal communication, such as body language (waving, gesturing) and facial expressions, such as winking.

Covert sensitization: A behavioral technique in which the deviant fantasy is paired with an unpleasant one.

Data gathering: The collection of as much information as possible about the client and the clients' system from as many different sources as possible, including (but not limited to) school records, court documents, medical records, prior treatment notes, victim statements, child

protective services documents, client statements, family members' statements and psychometric testing.

Denial: A psychological defense mechanism in which the youth may act shocked or indignant over the allegations of sexual abuse. Denial should not prohibit an abuser's opportunity for sexually abusive youth treatment.

Deviant Arousal: A youth's pattern of being sexually aroused to inappropriate stimuli. Since not all youth who abuse possess a deviant arousal pattern, the program should not require each youth to address arousal. The program must have a professionally accepted method for identifying and addressing arousal in youth who possess the pattern. The most common method is a phallometric assessment conducted by a trained and qualified sexual abuse treatment specialist.

Deviant Cycle: The pattern of specific thoughts, feelings, and behaviors which often lead up to and immediately following the acting out of sexual deviance. This is also referred to as offense cycle or cycle of offending.

Disposition: A final settlement of criminal charges.

Electronic Monitoring: An automated method of determining compliance with community supervision restrictions through the use of electronic devices.

Empathy: Identifying with or vicariously experiencing the feelings of another.

Evaluation: The application of criteria and the forming of judgments; an examination of psychological, behavioral, and/or social information and documentation produced by an assessment (sexual abuser assessments precede sexual abuser evaluations). The purpose of an evaluation is to formulate an opinion regarding a youth's amenability to treatment, risk/dangerousness, and other factors in order to facilitate case management.

Exclusion Criteria: The specific offender characteristics and level of risk which cannot be treated and managed safely and effectively in a treatment program.

Family: One's primary support system, including biological, adoptive or foster family; institutional or organizational "family"; family of choice, involving extended family members (uncles, aunts, grandparents, cousins, step-parents), neighbors, teachers, religious figures or other authority figures. Treatment providers should be inclusive rather than exclusive when considering who represents a youth's family.

Family and/or positive adult support: Parents, relatives or other positive adult friends who support a youth's reintegrating into the community and who understand the youth's risk factors, triggers, and cognitive deficits and who help the youth in development of self competencies and avoiding relapse. Youth has identified these individuals as resources or as someone whom s/he could seek for help.

Family assessment and evaluation: The family assessment utilizes the family as a source of data collection about the youth and the family unit. It identifies the strengths, resources, and problems of the family as well as determines the optimal and possible extent of the family's participation in treatment. The focus of the assessment is abuse-specific, concentrating on dynamics that may support offending behavior such as: over involvement or enmeshment, isolation, external and internal stress, intergenerational sexual or physical abuse, sexual history, impaired communication styles, conflicting parental relationship styles, emotional deprivation, and abuse of power.

Family circumstances: Current living situation, socio-economic status, cultural background, ethnic identity, members considered "family," mental, emotional and physical health of the family and individual family members.

Family clarification: The therapeutic family session in which the sexually abusive behaviors and events are made clear to everyone by the abuser.

Family contact: Physical, verbal and/or other interaction between a youth and his or her family (e.g., letters, visits, telephone calls, family emergencies such as serious illnesses and funerals, third-party contact in which the youth talks to another party who communicates to a member of the youth's family, etc.). Contact with family may mean personal phone contact by the youth or therapist, weekly structured conference calls with family members, individual family therapy sessions, multi-family sessions, family retreats, family visits, or communication through writing, video or audio tapes.

Family Reconciliation: The therapeutic process that ends with a resolution of problems and conflict areas that had prevented a family from having a healthy, non-abusive relationship. Family reconciliation must take place before family reunification can occur. Reconciliation may take place without reunification, although reunification should not occur without reconciliation.

Family reunification: The return to the family of a youth discharged from treatment. Reunification is a step-by-step process based upon achievable goals and objectives.

Family therapist: The person who will provide family therapy and coordinate treatment services. This person should be trained in child sexual abuse and have a knowledge of the theories and techniques of family therapy; the theories, techniques and applications for working with sexually abusive youth and their families; the laws and procedures for investigating and validating child sexual abuse; and the multi-disciplinary approaches to intervening and interacting with the relevant social system.

Family treatment plan: The guide for the family's involvement in treatment developed from the individual family assessment and evaluation. The family treatment plan has measurable, realistic, achievable and time limited goals and objectives.

Governing authority: The board, group or individual with the power and responsibility to establish and maintain the running of the program. The governing authority establishes policy criteria for costs, number of residents, hiring and firing of staff, dealing with the community and

media, and other administrative functions beyond the daily running of the program. The governing authority may be involved in the major decision-making of the program or be somewhat removed and be informed of issues on a periodic review basis.

Graduation or Discharge Readiness: Documented evidence of a youth's accomplishment of the treatment goals outlined in individual treatment plan.

Grooming: The active seeking out and manipulation of a victim for the purposes of engaging in deviant sexual activity.

High Risk Factors (HRF): A set of internal motivations or external situations/events that threaten a youth's sense of self-control and increase the risk of having a lapse or relapse. High risk factors usually follow seemingly unimportant decisions (SUDs).

Homogeneous: Population with similar treatment and living needs (e.g., age, cognitive ability, type of sexual offending behavior, mental health diagnosis, etc.).

Hygiene routines: All routines involving the use of the bathroom.

Incest: Sexual relations between close relatives, such as father and daughter, mother and son, sister and brother.

Individual Treatment Plan: A document outlining the essential treatment issues which must be addressed by the youth. Treatment plans often consist of core problem areas to be such as cognitive restructuring, emotional development, social and interpersonal skills enhancement, lowering of deviant sexual arousal, anger management, empathy development, understanding of the sexual abuse cycle, and the formulation and implementation of a relapse prevention plan.

Intake Procedure: The process of admission/reception into a treatment program.

Intensive residential treatment: Range of services which structure the youth's day and address inappropriate sexual behaviors, deficits in social skills, education, vocational needs, personal victimization issues, family of origin issues, and the other problems which contributed to offending behavior.

Interdisciplinary: Incorporates each component of the residential milieu, i.e., clinical, residential, educational, vocational, experiential, therapeutic community, etc. See multi-disciplinary.

Intrusive: The degree to which a treatment technique invades the usual physical and/or psychological privacy and/or functioning of a youth in order to address specific components of sexually aggressive behavior. Intrusive implies conducting treatment or utilizing specific interventions in a more extreme manner for the purpose of strengthening the therapeutic impact on the youth.

Justification: A psychological defense mechanism in which the youth attempts to use reasoning to explain offending behavior.

Knowledge of this mandate: The board of directors has been provided with sufficient information and training to make an informed decision to commit the agency to providing abuse-specific treatment.

Lapse: An emotion, fantasy, thought, or behavior that is part of a sexually abusive youth's cycle and relapse pattern. Lapses are not sex offenses. They are precursors or risk factors for sex offenses. Lapses are *not* failures and are often considered as valuable learning experiences.

Less Restrictive: Decreasing security offered by the physical structure (e.g., increased number of roommates), reducing the level/intensity of supervision, allowing greater access to unsupervised leisure time activities, permitting community or family visits, and/or moving into a level of care that has decreased restrictions.

Level of direct staff supervision: The ability of a staff member to maintain *complete line-of-sight visual supervision* of a youth.

Level of Risk: The degree of dangerousness a youth is believed to pose to potential victims or the community at large. The likelihood or potential for a sexually abusive youth to re-offend is determined by a professional who is trained or qualified to assess sexually abusive youth risk.

Meaningfully participate: A youth's ability to complete assignments, engage in group and individual treatment activities, comply with program rules, avoid risky situations associated with sex offense pattern, etc.

Minimization: An attempt by the offender to downplay the extent of the abuse.

Mixed groups: Any of the following would be considered a mixed group:

- Male and female sexually abusive youth in groups together
- Victims and offenders in group together (male offender/male or female victims; female offender/ male or female victims)
- Sexually abusive youth treated in specialized groups in facilities which contain another identified treatment population such as group homes, residential programs, hospital programs and training schools.
- Abuse-specific treatment programs housed in separate quarters in programs with general populations such as group homes, residential programs, hospital programs and training schools; residential programs in community settings.
- Youth in residential homes in community schools.
- Residential programs that use victims and victims groups as occasional guests.
- A mixture of different types of offenders such as hands-off offenders with hands-on; violent and nonviolent offenders; molesters and rapists; or adjudicated and non-adjudicated.

More restrictive: Increased physical structure, supervision, and treatment activity, restriction of mobility onsite and reduced access to offsite activities in response to lack of treatment progress, or significant rule breaking or noncompliance with program and milieu directives.

Multi-Cultural Issues: Any difference that exists between the language, customs, beliefs, and values among various racial, ethnic, or religious cultures.

Multi-disciplinary: Staff including clinical, social work, educational, medical, residential, and others. (See interdisciplinary)

Multi-Disciplinary Team: A variety of professionals (e.g., psychologists, psychiatrists, clinical social workers, educators, medical personnel, recreational staff, paraprofessionals, criminal justice personnel, volunteers, and victim advocates) who work together to evaluate, monitor, and treat sexually abusive youths.

Non-abuser-specific treatment modalities: Individual, group, family or experiential therapies that do not address abuser-specific issues and are delivered by a clinician who may or may not have abuser-specific expertise.

Outcome Data: Data regarding the effect of supervision and/or treatment on sexually abusive youth recidivism rate.

Outcome Design: The methods used to elicit information regarding treatment after treatment is completed, such as (but not limited to) attitudinal surveys, self-reports, assessment instruments, re-offense (recidivism) statistics. An outcome study is designed to determine whether the treatment services being provided have a direct influence on those receiving care, whether that care is delivered efficiently and achieves its intended result.

Paraphilia: A psychosexual disorder. Recurrent, intense, sexually arousing fantasies, urges, and/or thoughts that usually involve non-human objects, children, non-consenting persons or the humiliation of one's self or partner.

Parole: Prisoner release based on individual's progress within the correctional institution, which provides controls and guidance while serving the remainder of sentence in the community.

Particular risk level: The level of risk of youth accepted into a program determined by analyzing the nature of the abusive acts, the characteristics of the abusive youth, and the risk of re-abuse.

Permission to engage in program: Parent's and/or youth's agreement to participate in program's sex abuser-specific assessment and treatment modalities.

Phallometry (Phallometric Assessment or Penile Plethysmography): Device used to measure sexual arousal to both appropriate (age appropriate and consenting) and deviant sexual stimulus material. Stimuli can be audio, visual, or a combination.

Planned administrative discharge: In the event a resident is unresponsive to treatment over a significant period of time, s/he will remain in the program only until a more appropriate placement can be secured. The referring department is responsible for finding that placement within 30 days, unless the resident is an immediate threat. Residents are not kept in a program when there is a reasonable prognosis that the individual will not benefit from the program.

Planned successful discharge: The client has met the goals and objectives of his or her individual treatment plan.

Plethysmograph: A device that measures erectile responses in males to both appropriate and inappropriate stimulus material.

Positive treatment outcome: Significantly lower risk of sexually abusive behavior as a result of attaining/developing a higher level of internal control. Positive treatment outcomes include observable changes in behaviors, thoughts and attitudes associated with sexual abusing that indicate a significantly lower level of risk for abusing.

Precursors: Events prior to a sex offense including seemingly unimportant decisions (SUDs), maladaptive coping responses (MCRs), risk factors, lapses, and the abstinence violation effect (AVE).

Pre-sentence Investigation Report: A court ordered report prepared by a supervision officer which includes information about index offense, criminal record, family and personal history, employment and financial history, substance abuse history, and prior periods of community supervision or incarceration. At the conclusion of the report, the officer assesses the information and makes a recommendation to the court as to the disposition.

Probation: A court ordered disposition alternative through which an adjudicated offender is placed under the control, supervision, and care of a probation field staff member in lieu of imprisonment, as long as the probationer (offender) meets certain standards of conduct.

Previous victimization history: A youth's history of having been a physical, emotional and/or sexual abuse victim. An appropriate method for addressing this issue would include individual, group and/or family therapy. It must include the ability to adequately address significant traumatization issues, including personal safety within the program.

Progress in Treatment: Observable and measurable changes in behavior, thoughts, and attitudes which support treatment goals and healthy, non-abusive sexuality.

Psychopharmacology: The use of prescribed medications to alter behavior, affect, and/or the cognitive process.

Psychosexual Evaluation: A comprehensive evaluation of an alleged or convicted sexually abusive youth to determine the risk of recidivism, dangerousness, and necessary treatment. A

psychosexual evaluation usually includes psychological testing and detailed history taking with a focus on criminal, sexual, and family history. The evaluation may also include a phallometric assessment.

Range of Clinical Needs: Clinical needs of youth may include developmental, psychiatric, neuropsychological, cognitive, and psycho-social issues.

Range of clinical services: Individual, group, family, and experiential modalities that address issues such as prior traumatization, neglect, addiction, cognitive deficits, social skills, sexuality, and others.

Recidivism: In the broadest context, recidivism refers to the multiple occurrence of the commission of a crime, arrest, charge, conviction, sentencing, or incarceration.

Reintegration: A gradual, well-supervised re-acclimation or adjustment to a non-supervised, less structured environment featuring opportunities to demonstrate new social skills and responsible decision-making.

Relapse: A re-occurring sexually abusive behavior or sexual offense.

Relapse Prevention: A multidimensional model incorporating cognitive and behavioral techniques for treating sexually abusive/aggressive behavior. See *Appendix I* for listings of relapse prevention specific terminology.

Release of Information: The sharing of information among individuals managing sexually abusive youths (e.g., two-way information release between treatment providers and legal professionals includes the sharing of sexually abusive youth legal and treatment records and other information necessary for effective monitoring and supervision).

Required supervision level: Youth's need for direct contact with a person who will confront and report behaviors that break the treatment/aftercare contract or relapse prevention plan (e.g., parents only, parents plus tracker, probation/parole personnel, self-supervision).

Restrictive: The degree to which a program places limitations on, and/or externally controls, the youth's physical freedom, movement within the facility, access to the community, or other basic privileges. Locked treatment units with additional perimeter security and individual rooms for youth that are locked at night would be considered the most restrictive treatment setting. The use of locked seclusion rooms and policies forbidding supervised community outings for youth would be considered very restrictive intervention techniques.

Restitution: A means of giving back or ameliorating the harm done to the victim, his/her family, the community or society. In cases where property is damaged or destroyed, a monetary figure may be determined. When a person has been personally victimized, it is often difficult or impossible to come up with a means to reverse the damage.

Reunification: A gradual, well-supervised procedure in which a sexually abusive youth (generally an incest abuser) is allowed to integrate back into the home where children are present. This takes place after the clarification process and includes a detailed plan for relapse prevention.

Risk assessments: Determination of immediate and long-term potential to commit a harmful act in the program or the community through consideration of the nature, extent and seriousness of the youth's sexually abusive behavior, the degree of threat the youth presents to the community or victim, and the general dangerousness of the offender in any particular setting. Risk assessment is required before making any admission and placement decisions. It determines specifically and in detail the appropriate setting, the intensity of intervention, and the level of supervision needed by the particular youth.

Risk Controls: External conditions placed on a sexually abusive youth to inhibit re-offense. Conditions may include levels of supervision, surveillance, custody, or security. In a correctional facility, these conditions generally are security and custody related. In a community setting, conditions fall in the realm of supervision and are developed by the individual charged with overseeing the sexually abusive youth's placement in the community.

Risk Factors: A set of internal stimuli or external circumstances that threaten a sexually abusive youth's self-control and thus increase the risk of lapse or relapse.

Risk level: Youth who exhibit fewer offenses, less violence, less denial, a willingness to engage in treatment, few or no collateral issues (e.g. substance abuse, cognitive deficits, learning disabilities, neurological deficits, use of weapons), are considered lower risk than those who profile with more offenses, greater violence, etc. Risk level is changeable, depending on behaviors exhibited within the program and/or on disclosures of additional previously unknown offenses.

Risk Management: A term used to describe services provided by corrections personnel, treatment providers, community members, and others to manage risk presented by sexually abusive youths. Risk management approaches include supervision and surveillance of sexually abusive youths in a community setting (risk control) and requiring sexually abusive youths to participate in rehabilitative activities (risk reduction).

Risk Reduction: Activities designed to address the risk factors contributing to the youth's sexually deviant behaviors. These activities are rehabilitative in nature and provide the sexually abusive youth with the necessary knowledge, skills, and attitudes to reduce his/her likelihood of re-offense.

Room assignments: Placement in rooms determined by youth's level of risk to abuse or be victimized by other youth in the program.

Safely manage: Minimizes the potential for the youth to engage in any further sexually, physically, or verbally abusive behavior toward peers, staff, or community members while in the program, whether on site or off, and includes safeguarding the youth from self-harm.

Safety policies, procedures and standards: Written statements and the practices specifically designed to insure that residents are protected from physical and psychological victimization while receiving treatment in the program. Since there is always the possibility of sexual, physical or psychological victimization taking place, the program must have a treatment model to address such issues.

Seemingly Unimportant Decisions (SUDs): Decisions sexually abusive youths make that seem to them to have little bearing on whether a lapse or relapse will occur.

Sexual Abuser: Individual who engages in sexual behavior that is considered to be illegal or harmful to others.

Sexual abuse-specific assessment: Includes the recognition that confidentiality is limited, the client often involuntary, and society must be protected while addressing abuser's needs. Data gathered during sexual abuse-specific assessments may have legal implications. Identification of deviant arousal, sexual thoughts and behaviors, and personal or behavioral characteristics that encourage or support healthy or abusive behavior are critical components of the assessment and evaluation process.

Sexual abuse-specific therapy: Individual, group, family and experiential therapies addressing the specialized needs of this youth population. Those needs include internalization of self-control, deviant arousal reduction, management of inappropriate fantasies, victim empathy, victimization history, development of healthy sexuality, correction of cognitive distortions, knowledge of and ability to intervene successfully in an assault cycle, and knowledge and use of a relapse prevention plan.

Sexually abusive: Sexual behaviors that are not consensual. One party has greater power (physical size, strength, knowledge, sophistication, etc.) over the other. Age differences (e.g., one party being 17 and the other 12 years old) can make a seemingly consensual relationship sexually abusive due to legal definition. Developmental issues such as mental handicaps or temporary conditions that affect judgment such as intoxication limit an individual's ability to give consent. See also Consensual.

Sexually aggressive: Sexual behaviors which involve force, coercion, threats, or other means to make a victim comply. While perpetrators may not believe their behaviors are aggressive, particularly where the victim complies or cooperates with the request or demand, the primary consideration is that the victim did not wish to engage in the behavior and the act is perceived by the victim as one of aggression.

Sexual Assault: Forced or tricked sexual contact which need not but can include touching.

Sexual Contact: Physical or visual contact involving the genitals, language, or behaviors of a seductive or sexually provocative nature.

Sexual Deviancy: A pattern of being aroused by inappropriate sexual stimuli in which there is a high probability of behaving in a sexually assaultive manner. Sexual deviancy can include inappropriate partners or inappropriate behaviors.

Sexually abusive youth: An individual who has been charged and convicted of illegal sexual behavior as defined by the law. Not all sexually abusive youths meet the diagnostic criteria to be considered as having a paraphilic disorder as defined by the DSM-IV.

Social contact: Non-sexual interactions between a sexually abusive youth and others not in the program. This may include written, telephone or personal interactions between a sexually abusive youth and a sibling or relative whom the youth victimized.

Statement of Informed Consent: A clinical document signed by a sexually abusive youth which becomes part of the treatment record and may be admissible in court. It implies that the sexually abusive youth understands the benefits and risks of a particular treatment procedure and may voluntarily withdraw from the procedure without consequence.

Successful completion: Demonstrated skills and abilities required for safe discharge/graduation from the program.

Sufficient space: Youth can sit in all meeting rooms with at least an arm's length of distance between them; youth can sleep in a bed without being able to reach out and touch another youth; youth can move from activity to activity without needing to physically touch any other youth.

Thinking error: See Cognitive Distortion.

Tracks or units: Tracks include treatment, educational and recreational activities. Units indicate housing and may include treatment, educational and recreational activities.

Treatment agreement: A written explanation of what is expected from all parties involved in the treatment process for the youth. This includes the youth, his parent or guardian, clinician or administrator for the program, as well as the organization(s) responsible for payment and enforcement of the youth's compliance (i.e., probation officer.) Although this is not necessarily a legal document, it should express the expectations of all parties for the successful completion of treatment and note potential consequences for failure to complete the program.

Treatment and site capability: The program's ability to safely treat and manage a defined level of youth risk. It is understood to include the physical characteristics of the program's site; staff-to-youth ratios; the level of acting out which can be safely managed by the program's behavior management system; and the skill level of the staff.

Treatment contract: A document explained to and signed by the youth, his or her parent, guardian, or a representative of the custodial agency, and a representative of the treatment program.

Treatment progress: Includes but is not limited to demonstrating ability to learn and use skills specific to controlling abusive behavior, identifying and confronting distorted thinking, understanding assault cycle, accepting responsibility for abuse, dealing with past trauma and/or concomitant psychological issues, including substance abuse/addiction.

Triggers: See Precursors.

Unplanned unsuccessful discharge: The client leaves or is removed from treatment before all treatment goals are met.

Victim Impact Statement: Statement taken while interviewing the victim during the course of the pre-sentence investigation report with the purpose of determining the impact of the sexual offense on the victim.

Victim-stance: A tendency for offenders to consider themselves the real victim, no matter how aggressive their behavior toward other people.



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