

CASOMB's
Guidelines for
Treating and
Supervising Youth
Who Have
Committed a Sexual
Offense



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Executive Summary

Youth, ages 13-17, are significantly different from adults in virtually all aspects of life. For this reason, society restricts their right to drive a car, vote, purchase tobacco, alcohol or marijuana, consent to medical treatment, and serve in the military. Youth are in a developmental stage of life in which rapid changes and maturation processes are affected by many forces, including biological, familial, educational and social. Youth who have offended sexually have a low likelihood of committing a new sexual offense, with estimates as low as 2.75%. Common methods of supervision and treatment used with adult sexual offenders are, for the most part, inappropriate and potentially harmful with youth. The Board strongly recommends that youth who have offended sexually should have services specialized for their needs.¹

Historically, the majority of services have been provided at the county level. With the closure of the Department of Juvenile Justice and the statewide realignment, all adjudicated youth will be retained at the county level for commitments and supervision. Resources and access to treatment services vary by county. Even when treatment is available, there is no statewide standard of care for youth who have offended sexually. Agencies, organizations and individuals who provide services to this population need standards based on what research shows to be the best approach to assure quality and consistency of services during intake, treatment, residential changes, treatment completion, and family reunification. ***In this document the Board has developed evidence-based standards and guidelines for a collaborative model of treatment and supervision of youth, supported by the principles of Risk-Need-Responsivity (RNR).*** These guidelines should apply for youth adjudicated for committing a sexual offense, and referred to attend sex offense specific treatment by the court. The intensity of services will be defined by individualized assessments of risk and treatment needs and managed by a case management team.

These standards will form the basis for specialized training for supervising officers and, if approved by legislation, specialized certification standards for treatment providers working with the youth population. The standards and potential certification requirements for providers who work with youth, must be distinct and separate from the Board's existing certification requirements for treatment professionals who work with adults. ***Given the necessary resources and jurisdiction CASOMB will monitor certified programs and treatment providers to assure delivery of services that are sensitive to the youth's needs and provided in culturally sensitive and trauma informed manner. Minor statutory changes will allow SARATSO to resume its role of selecting risk instruments for youth who have committed sexual offense.***

¹ California Sex Offender Management Board (CASOMB). (2019, January). *Juvenile Recommendations*. Retrieved: https://casomb.org/pdf/CASOMB_Juvenile_Recommendations_January_2019.pdf

Introduction

The purpose of the *Guidelines for Treating and Supervising Youth who have Committed a Sexual Offense* is to promote policies that achieve two primary goals:

1. Reduce both sexual and general criminal recidivism for youth.
2. Promote the prosocial and positive development of these youth and their future emotional, interpersonal, and occupational success.

Youth typically have low recidivism for sexual behaviors, one estimate indicates 2.75%. This means that only about 3 in 100 youth will commit a new sexual offense after being adjudicated. Nonsexual or general criminal recidivism is estimated to be 10 times higher than sexual recidivism.² This population also has a high prevalence of co-occurring psychiatric conditions including Attention Deficit Hyperactivity Disorder (ADHD), family dysfunction, trauma, mood disorders, learning disorders, and substance use problems.³ Research indicates that treatment of such factors is important not only to promote the prosocial development of these youth but also may have an impact on decreased recidivism.⁴ The low recidivism rate and development changes highlight the differences between youth and adults and the need for separate guidelines and practices for each population.

The following describes concepts important in the development of these youth guidelines that distinguish them from adult standards:

Neurodevelopment - Adolescence is a period of rapid physical, sexual, and brain development.⁵ Areas which control decision-making are still developing. Immaturity in this area may contribute to harmful sexual or other problematic behaviors, while development in these areas during adolescence contributes to their desistance.⁶ Treatment methods which promote psychosocial maturity are likely to reduce recidivism.

Collaborative model - The recommended model for providing services for Youth is the Collaborative Model. This model is appropriate for adolescents, and is distinct from the adult model Containment Model.

² Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. *Psychology, Public Policy, and Law*, 22(4), 414–426. <https://doi.org/10.1037/law0000094>

³ Epperson, D.L., & Ralston, C.A. (2015). Development and Validation of the Juvenile Sexual Offense Recidivism Risk Assessment Tool–II. *Sexual Abuse*, 27(6), 529–558. <https://doi.org/10.1177/1079063213514452>

⁴ Lipsey, M., Howell, J., Kelly, M., Chapman, G. & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: a new perspective on evidence-based programs*. Center for Juvenile Justice Reform, Georgetown University.

⁵ Jensen, F.E., & Nutt, A.E. (2015). *The teenage brain: A neuroscientist's survival guide to raising adolescents and young adults*. Harper Collins Publishers.

⁶ Steinberg, L.D., Cauffman, E., & Monahan, K. (2015). *Psychosocial maturity and desistance from crime in a sample of serious juvenile offenders*. Office of Juvenile Justice and Delinquency Prevention.

Risk-Need-Responsivity (RNR) – The RNR model provides a framework for assessment that informs effective treatment and interventions. Juvenile instruments for assessing sexual recidivism and general criminal recidivism are generally as accurate as adult measure. Along with other information they can provide essential information for disposition and treatment planning.

RNR assessments provide information that facilitates risk reduction and prosocial development. Given that adolescents who have engaged in sexually abusive behavior are more likely to reoffend nonsexually, it is important that assessments address general risk. Assessments should focus on providing a broad, multidimensional assessment of the individual adolescent's treatment and support needs. This includes addressing issues that may impact the adolescent's response to interventions, such as language barriers or cognitive deficits. To be effective, assessments should focus on issues that impact healthy adolescent development and identify strengths and protective factors.⁷

Assessment - Given the high prevalence of co-occurring psychiatric conditions, nonsexual recidivism, and the need to identify types and risk levels for problematic sexual behaviors, comprehensive psychological evaluation using evidence-based methods and measures is recommended for these youth.⁸ This should include measures of sexual and general criminal recidivism and also assessment of mental health needs and substance abuse issues.

Treatment - Treatment and disposition planning for youth should be evidence-based, and comprehensive. Treatments to reduce the risk of sexual recidivism should be complemented by treatments to reduce general recidivism, and treat co-occurring mental health factors. Treatment methods should incorporate evidence-based criteria which emphasize skill-building and problem-solving. Counseling methods should be matched to the youth's risk level and learning styles, and incorporate quality assurance and treatment outcome measures. Treatment approaches should also be "trauma-informed" and culturally sensitive.⁹

The following guidelines are provided to promote good quality RNR assessments that help inform decisions and interventions to prevent further offending, reduce future victimization, and promote community safety.

Recommendation Requirements for Treatment Provider Education, Experience, Training and Supervision:

Mental health professionals who provide therapeutic treatment services for youth who have offended sexually need to have specialized training, education, and experience that prepare them

⁷ Association for the Treatment & Prevention of Sexual Abuse (ATSA). (2017). *ATSA Adolescent Practice Guidelines*. Retrieved:

https://www.atsa.com/Members/Adolescent/ATSA_2017_Adolescent_Practice_Guidelines.pdf

⁸ Land, R., Ralph, N., Rasmussen, L., Miccio-Fonseca, L.C., & Blasingame, G. (2013) *Guidelines for the Assessment and Treatment of Sexually Abusive Juveniles*. California Coalition on Sexual Offending (CCOSO).

Retrieved: <https://ccoso.org/sites/default/files/Adol%20Guidelines.pdf>

⁹ Land et al., 2013

to work within this field. Assessment and treatment of youth who have committed a sexual offense, requires significant clinical skill and experience. A competent therapist will have specialized knowledge and training, and the skills to utilize techniques that are based on empirical evidence. Maintaining and demonstrating evidence of one's scope of practice and scope of competence in working with youth who have offended sexually is the legal and ethical responsibility of each licensed psychotherapist in California treating these individuals.

1. Eligibility to Practice

Individuals who provide treatment services in California may work independently and provide supervision to those who do not meet the criteria to work independently. An independent provider must be licensed to provide mental health services in the state of California, per the Board of Behavior Science, Board of Psychology, or Medical Board.

2. Education

The provider's education should be consistent with the requirements to become licensed within the state they practice.

3. Experience

In order to provide services independently, under CASOMB's Guidelines, a provider must have sufficient experience in the treatment and evaluation of youth who have sexually offended. The provider must have completed 750 hours of direct experience providing sex offender specific individual, group or family therapy, , or evaluation within the last 5 years or 2000 hours over the course of their lifetime. No more than 20% of the experience can be accrued while providing services to youth for nonsexual offenses.

4. Training/Continuing Education

In order to maintain the most current and up to date evidenced based practices, the provider must complete 24 hours of training or continuing education every two years. The training should focus on topics related to the treatment, evaluation, development, research, and supervision of youth who have committed a sexual offense.

5. Clinical Supervision

If providing supervision, to unlicensed providers or those new to the field, the Independent supervisor must ensure that the unlicensed provider meets the qualifications for providing mental health services in the state of California (or the state in which they practice). Supervision should be provided in such a way that it supports the growth and development of the unlicensed provider or the licensed provider who is new to the field, and should meet all licensing Board requirements for supervision. A minimum of one hour of face-to-face supervision should be provided to those who do not meet the requirements for Independent status. Due to the nature of forensic work it is important that providers incorporate self-care and training for the prevention and treatment of vicarious trauma, both for themselves and for those they supervise.

Treatment Provider Agency Requirements

The agency guidelines are organized into several key areas:

1. Implementation of the Collaborative Model
2. Placement of Youth
3. Use of Polygraph
4. Informed Consent Paperwork
5. Assessment
6. Treatment Plan
7. Treatment Modalities
8. Treatment Completion
9. Other Documentation

1. Implementation of the Collaborative Model

The Collaborative Model of youth supervision “is used in several ways and mirrors characteristics of many of the systems with which the youth interacts. It is intended to create an optimal relationship between the youth, his or her family, probation, and treatment providers.”¹⁰ The Collaborative Model emphasizes a team approach and promotes the prosocial behavior of the youth while also protecting public safety. This method goes beyond managing potential inappropriate behavior in the community.¹¹ Supplementing the Collaborative Model with the RNR principles helps clinicians and supervising officers enhance outcomes by delivering individualized therapeutic intervention and supervision.¹²

The Collaborative Model relies on open and consistent communication between the probation officer and treatment provider. Communication should occur at a minimum once a month, and regularly scheduled meetings are encouraged. Regular meetings allow the treatment and supervision team to share information in a comprehensive, coordinated, collaborative approach to identify, manage, support and supervise youth adjudicated for sexual offending behaviors.

Additional meetings and communication should take place with the Case Management Team (CMT). The CMT should include the probation officer, the treatment provider, the youth and other key stakeholders involved in the youth’s life, such as the youth’s family or guardian, mentor, social worker, psychiatrist, school representatives or members of the Child and Family Team (CFT).¹³ The additional key stakeholders should attend as needed. The goal of the CMT communication is to collaboratively work with the youth and individual’s in their life to promote a comprehensive holistic plan for the youth’s success. Promoting prosocial values through the CMT will increase community safety.

¹⁰ Land, R. et al., 2013, p. 7.

¹¹ Land et al., 2013

¹² Land et al., 2013; CASOMB Juvenile Recommendations, 2019

¹³ Welfare & Institutions Code, §§ 727(a)(4)(A), 727.1(a), 727.2, 16501(a)(4).

A. Risk Level Assessment

Empirical risk assessment of youth in the community is an optimum way to inform the Case Management Teams of the risk level of the person they are treating or supervising.¹⁴ California law required the use of risk assessment instruments only for juveniles recommended for placement or after placement at the highest level of state supervision at DJJ. The State Authorized Risk Assessment Tools for Sex Offender (SARATSO) committee mandated the use of the JSORRAT-II be scored for this purpose. Starting on July 1, 2021, changes made as a result of SB823, voided this requirement. In line with best practices, it is recommended that youth, who are eligible for scoring, be assessed by probation post-adjudication and pre-disposition with a risk instrument, such as the previously SARATSO selected JSORRAT-II or other risk instrument for youth, which is valid and reliable. A valid and reliable instrument is one that research has shown, not just once but several times, by the test developers and other researchers that it consistently measures what it is intended to measure. A process and structure is in place for the SARATSO Review Committee to select relevant risk instrument and to train scorers statewide. SARATSO should be given the statutory purview to implement this process for youth adjudicated of a sexual offense.

B. Supervision Decisions Guided by Evidence-Based Standards

Frequency and type of treatment, supervision methods, Internet usage, contact with families, use of GPS (global positioning systems), and limited use of polygraph exams are all examples of the types of decisions that should be made by the collaborative team. Methods of supervision must be appropriate and consistent with public safety and accountability of the youth. This includes referral for mental health needs, substance abuse issues, or educational needs. Decisions regarding supervision methods should be based on results of a comprehensive assessment of the youth and the judgment of the CMT.

C. Specialized Caseloads and Training

When feasible, probation officers should supervise this population on specialized caseloads for youth who have committed sexual offenses. Probation officers with this caseload should receive specialized training to enhance their ability to effectively supervise youth, in order to protect the community, reduce recidivism, and assist with prosocial development. Supervising officers should attend training about juvenile brain development as it relates to effective supervision practices for youth. Supervising officers must also learn effective methods for communicating with the treatment provider agencies, and caregivers, and how to use the Collaborative Model effectively. This includes understanding how to interpret risk assessment scores and clinical recommendations. Supervising officers handling these caseloads should receive specialized training during their first year of assignment to this type of caseload.

¹⁴ CASOMB Juvenile Recommendations, 2019

2. Placement of Youth

A. Out of Home Placements

Out-of-home placement is pursuant to the Welfare and Institutions Code,¹⁵ which states that all youth in placement are to have a child-centered service plan including parental participation on the Child and Family Team.

Youth who have offended sexually are often removed from their family homes. Sometimes this is because their victim(s) live in the family home. Other times it is because the youth is beyond the parents' capacity to control, there is no viable family placement, or the youth's offense(s) are particularly egregious. Some youth are simply thought to be too high risk for community placement. Research indicates, even for youth with high levels of risk, there is no incremental benefit for out of home placement relative to community placement. Best practices indicate that the least restrictive environment be identified and with family wherever possible.

Congregate care is an important component to the continuum of care for this population. It is an appropriate option for youth with treatment needs that cannot be met through outpatient treatment. It is a valuable intermediary for youth who need the strict supervision that residential treatment can provide, while providing them with a chance to address their sexual problems and offending behaviors without the potential consequences that come with registration requirements. With the requirements on Short Term Residential Treatment Programs (STRTPs), there are expectations that residential programs include trauma-informed care and utilize certain assessments. The Board believes that youth who have offended sexually, and who are placed in STRTPs, should receive additional support and services specific to this population, that would translate needs and treatment outcomes across placement settings.

The Board believes that regardless of where the youth lives, he or she should receive the best possible support and services, and that family reunification should be the goal in all feasible cases consistent with community safety and the youth's best interests. The Board believes that statewide, systemically and similarly organized services should be accessible across the continuum of care for youth who have offended sexually. Youth who are placed in the community may at a later time need a higher or lower level of placement. Likewise, youth who are placed in an institutional setting will eventually be released to a community placement or their families. With youth-specific certified treatment programs and providers adhering to these Board requirements, regardless of placement setting, youth will be able to receive similar care with evidence-based methods and methodologies.¹⁶

¹⁵ Welf. & Inst. Code, §§ 727(a)(4)(A), 727.1(a), 727.2, 16501(a)(4).

¹⁶ CASOMB Juvenile Recommendations, 2019

Such consistency does not exist at this time. If a youth is moved from one placement to another, he or she is likely to have to start a new treatment program. Prior treatment efforts are often set aside as each independent treatment program or provider has their own strategies and methods. Some individuals transferring from one program to another have been required to rewrite prior documents solely to include the new program's terminology. Other individuals are not credited for treatment efforts done elsewhere if a copy of those materials is not available to the new program.

For these reasons, the Board believes it is in the interest of public safety and youth offender rehabilitation that these Board recommendations apply to all treatment service providers regardless of the youth's residence or placement setting.

B. Juvenile Court Transfer

Under current law, a prosecutor may make a motion to transfer a minor who is 16 or 17 years of age from juvenile court to a court of criminal jurisdiction in any case in which the minor is alleged to have committed a felony. Most youth would not be considered routinely for such a transfer, and this is usually expected to apply only in extraordinary situations. The Youth Guidelines highlight how different youth are from adults. This corresponds with a lower recidivism rate for youth, estimated at approximately 2.75%.

The Centers for Disease Control has concluded: “[T]ransfer policies have generally resulted in increased arrest for subsequent crimes, including violent crime, among youth who were transferred compared with those trained in the juvenile justice system. To the extent that transfer policies are implemented to reduce violent or other criminal behavior, available evidence indicates that they do more harm than good.”¹⁷ Over the past 10 years, in California, the number of transfers from youth to adult court has significantly decreased. Youth will benefit from remaining in the juvenile justice system and receiving developmentally appropriate services.

For a detailed description of the juvenile court transfer process please see Appendix C.

3. Use of the Polygraph

Polygraph exams in supervising youth in this population should not be the norm, should be rarely used only when justified on a case-by-case basis. Best practices indicate that its use should be limited to youth age 16 or 17.

- Any use of polygraph in California with juveniles should be governed by youth-centered standards developed by the Board for both treatment and polygraph which are developmentally suitable and empirically based. The decision whether to use polygraph with youth, and what

¹⁷ Hahn, R., et al., (2007). *Effects on Violence of Laws and Policies Facilitating the Transfer of Youth from the Juvenile to the Adult Justice System*. Center for Disease Control and Prevention, Morbidity and Mortality Weekly report, 1-11, p. 9.

type of exam is indicated and in what circumstances, should be guided by standards to be promulgated by the Board.

- Polygraphs should not be used with any youth under the age of 16.
- In rare cases, a polygraph exam may be conducted with a youth age 16 or 17, if recommended by the youth's CMT.¹⁸ Polygraph is only recommended in situations in which it is necessary to maintain community safety, due to the concern of an imminent sexual offense. The CMT should consider factors such as age, trauma background cognitive development, treatment issues (e.g., denial), and potential harm to the youth prior to determining if use of polygraph would be appropriate in a particular case.
- Polygraph examinations results cannot be used for determining whether family reunification, or incarceration, is appropriate.
- Any use of polygraph with youth requires appropriate use immunity, such as offered in Oregon.¹⁹ California law provides similar immunity protection, as explained in *People v. Garcia* (2017) 2 Cal.5th 792. California law conferring legal protection from disclosures should be explained in the standards, and the parameters of the polygraph examination should be defined (pre-polygraph interview, polygraph exam, post-polygraph interview).
- If a polygraph examination is required, then appropriate waivers of confidentiality, must be provided to the youth and their parent/guardian.
- Polygraph examiners working with youth require a specified amount of training hours in youth cognitive development as well as experience conducting polygraph exams with youth.²⁰

Polygraph exams should be coordinated by the CMT, with input from the treatment provider and probation officer. Polygraph exam reports must be provided to the treatment provider and polygraph examiner within 5 days of the exam. Requiring a second polygraph due to inconclusive, or significant responses is not recommended.

4. Informed Consent, Waiver of Confidentiality, Release of Information, Treatment Contract

The provider agency shall have forms for obtaining Informed Consent to Treatment, Waiver of Confidentiality, Authorization for Release of Information, and a Treatment Contract, that should be reviewed with both the youth and the youth's parent/guardian or caregiver. All forms should be at a 4th grade reading level, and the treatment provider should ensure all forms are easy to understand for the youth. For youth or families with reading challenges, oral review of the content of these documents is recommended. For non-English speakers, a translator should be used to provide written or oral explanation in the appropriate language. Attention needs to be given so that the match between the translator's language skills and those of the youth and family is appropriate given dialect differences between regions.

¹⁸ ATSA, 2017

¹⁹ Hindman, J. & Peters, J. (2001). Polygraph Testing Leads to Better Understanding Adult and Juvenile Offenders. *Federal Probation*, 65(3), 8-15.

²⁰ CASOMB Juvenile Recommendations, 2019

A. Informed Consent/Treatment Contract

Youth and their parent/guardian should understand the screening, assessment and treatment processes prior to the onset of services. Youth participating in treatment and/or screening and their legal guardian (if not an emancipated minor) are required to give informed consent for assessment and treatment. Provider agencies or providers should use language that each client can comprehend. Youth who refuse treatment must be advised that refusal to give consent can result in not being accepted in the treatment program. The provider agency must ensure that the youth has the capacity to understand and give informed consent.

The roles and responsibilities of the provider agency and what is expected of the youth and their parent/guardian should be included. Such agreements can be particularly useful in establishing the youth's responsibility, accountability, and ownership with respect to his or her engagement in treatment. They document in writing that the youth and parent/guardian have been informed of the conditions and requirements of the treatment program as well as the consequences of violating these conditions. Treatment consequences may include written warnings, remediation plans, suspension, or discharge from treatment. The youth and parent/guardian should be made aware that their status in treatment may impact compliance with the conditions of probation.

The following components should be included in the informed consent form:

1. A description of the assessment and treatment processes
2. Description the type, frequency, and requirements of the treatment program, and outline how the duration of treatment will be determined;
3. A statement regarding the possible benefits and risks of treatment, and possible adverse effects of treatment
4. Consequences of refusing to participate in treatment
5. Alternative forms of treatment, for example whether or not to take a medication
6. An explanation of the limits of confidentiality including the possible legal impact of disclosures
7. Training, education, and experience of the treatment provider
8. Name and contact information for the clinical supervisor of unlicensed providers
9. An explanation of the nature of, limitations and boundaries of the therapeutic relationship
10. A statement allowing for open, two-way communication between the professional staff members within the provider agency to facilitate communication related to supervision, consultation, case conferencing, back-up, and other interagency communications
11. Information about client fees for assessment, treatment, polygraph examinations and other costs. The fee schedule should comply with Federal No Surprises Act.
12. A statement explaining client rights and responsibilities, including maintaining the privacy and confidentiality of other persons who are in the treatment program
13. A description of the agency's internal complaint process and the CASOMB complaint process
14. For internal research the provider agency must state its policy on the use of file information for research and on the solicitation of client participation in research projects, whether within the agency or by outside investigators.

15. Define the **role and responsibilities of the youth and parent/guardian** (as applicable) with respect to, at a minimum, the following areas:
 - a. Describe and clarify program rules and behavioral expectations;
 - b. Describe compliance with attendance policies and procedures for handling cancellations and tardiness
 - c. Describe expected participation in assessments, treatment sessions and treatment homework
 - d. Describe provider's expectation that the client notify the treatment provider of any changes or events in the life of the client, the members of the client's family, or support system;
 - e. The expectation of the parent/guardian to support the youth and/or participate in some level of treatment or classes.
 - f. Describe any other provider agency rules and requirements to which clients are expected to adhere.

NOTE: The above list is not intended to be a legal guide or a comprehensive, authoritative review of all the elements required for informed consent.

B. Waiver of Confidentiality

Youth and their parent/guardian must clearly understand that they will be expected to give their written permission (*Waiver of Confidentiality* or *Authorization for Release of Information*) for the provider agency to share information about them with supervising officer and members of the CMT. A provider shall explain to youth that information disclosed in a mental health treatment context is confidential with certain exceptions. The other limits of confidentiality, such as child abuse reporting, elder abuse reporting, *Tarasoff* warnings, and suicidality should be enumerated.

The waiver must explain that the following entities are required to communicate openly with each other regarding risk related information: supervising agency, treatment provider agency, and other key members of the CMT. A separate release of information form must be generated and signed for the polygraph examiner if a polygraph examination is conducted.

The provider agency's waiver of confidentiality form must meet professional standards of practice and must be written so that it can be understood by the individuals who are required to sign it. In accord with the Health Insurance Portability and Accountability Act (HIPAA) regulations, the provider agency must provide a statement of its privacy practices which addresses the handling of confidential client information and documents.

C. Authorization for Release of Information

Providers must obtain a signed authorization to exchange information with other entities.

1. CASOMB conducts compliance reviews of providers and provider agencies. Authorization to Release Information must include CASOMB or the CASOMB designee.

2. Communication with adjunct participants (youth mentors, school representatives, etc.) in the CMT team requires a release of information.
3. If the offender has additional therapists or treatment providers external to the certified provider agency, a separate release shall be arranged for each of the professionals involved.
4. When working toward reconciliation, a release of information for the victim's therapist, shall be signed.
5. External consultants or external clinical supervisors involved with the treatment program shall also be listed on the release of information forms before a case is discussed with them.

5. Assessment

Comprehensive assessments are the foundation for identifying risk levels, treatment targets and needs, and responsivity related issues. Relevant factors that are to be addressed as part of disposition and treatment planning need to be reliably assessed using evidence-based best practices. A comprehensive evaluation should include clinical interviews with the youth and their parent/guardian, a thorough document review, collateral contacts when appropriate, and psychological tools. A comprehensive psychological assessment should be completed, by a qualified licensed mental health provider, for the youth post-adjudication and pre-disposition. If a comprehensive evaluation is unable to be completed pre-disposition then it should be completed prior to or concurrently with the commencement of therapy, and should include the following elements:

- Assessment of sexual recidivism risk using a validated risk instrument for sexual re-offense
- Assessment of general criminal recidivism using a validated instrument
- Prior delinquent behavior
- Comprehensive assessment of co-occurring psychiatric factors, including mental health issues, substance use problems, adverse childhood experiences, trauma history, and family factors.
- Given the high rate of learning and cognitive disorders for this population, assessment of cognitive and academic functioning, is necessary. Formal cognitive and academic testing which has been recently completed, by schools or associated organizations can be integrated into assessment findings.
- Social and familial relationship history
- Pertinent medical history
- Factors which impact engagement, motivation and amenability to treatment

Areas to be assessed include static factors which describe historical aspects of the youth likely not to change and dynamic factors related to the youth's current situation, experiences, environment, and beliefs, which may be changeable.²¹ Research regarding instruments is ongoing and the

²¹ Worling, J. R. (2004). The estimate of risk of adolescent sexual offense recidivism (ERASOR): Preliminary Psychometric Data. *Sexual Abuse*, 16(3), 235–254. <https://doi.org/10.1177/107906320401600305>

selection of instruments should be based on current research and best practices. The use of such measures provides one source of data regarding how treatment planning should be structured to account for the risk of recidivism.. Probation departments, state agencies, and treatment providers may make selections among available instruments.

General Criminal Recidivism Measures: Parallel to the use of sexual recidivism measures, it is essential to assess the youth's risk of general criminal recidivism or nonsexual crimes. Nonsexual crimes for youth occur at about 10 times the rate of sexual crimes and have victims too. Scientific criteria for use of such measures is the same as those described for sexual recidivism measures. A number of instruments are available in this area that have acceptable research findings. These instruments provide assessment of areas of focus for disposition and treatment planning.

Mental Health Needs: ADHD, anxiety disorders, mood disorders, PTSD, familial challenges, and substance use, among other factors, should be assessed. These conditions have a high prevalence in this population.²² When such factors are adequately assessed it is more likely that the dual goals, reducing recidivism and promoting the prosocial functioning of youth will be achieved. These factors are assessed by mental health methods which include clinical interview, review of history, and use of appropriate psychological tests.

Cognitive, academic, and neuropsychological factors: Youth have a high incidence of learning problems. One study notes for youth in detention for general probation issues, 35.6 percent were learning disabled, and 12.6 percent had an intellectual disability.²³ For some youth with a history of neuropsychological disorders, specific neuropsychological assessment may be warranted. Referral issues might include a history of head injury, brain cancer and/or chemotherapy, prenatal substance abuse exposure, autistic spectrum disorders, or genetic or perinatal conditions (e.g., fetal alcohol syndrome or microcephaly).

Reassessment: Dynamic factors which may impact recidivism and prosocial development should be reassessed to determine the need for additional treatment, some of which may extend beyond the probation period

6. Treatment Plan

The provider agency shall develop and make consistent use of a written treatment plan for each youth that articulates treatment goals agreed upon by the CMT. The treatment plan should be reviewed with the youth and may include the case management team. The initial review, should occur within 60 days, and shall not exceed 120 days. Treatment Plan should be periodically reviewed and updated. Updated treatment plans should be shared with the CMT. Quarterly reviews is a standard practice.

²² Epperson, D.L., & Ralston, C.A. 2015

²³ Casey, P., & Keilitz, I. (1990). *Estimating the Prevalence of Learning Disabled and Mentally Retarded Juvenile Offenders: A Meta-analysis* (Report No. 124182). U.S. Department of Justice Office of Justice Programs. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/estimating-prevalence-learning-disabled-and-mentally-retarded>

The treatment plan articulates a set of achievable goals and evidence based interventions that provide a way to measure and record progress or the lack of progress toward those goals. The treatment plan should allow a way for the program to assess the level of compliance and effort demonstrated by the participant.

Treatment planning and delivery follow RNR principles. A written treatment plan shall be developed for each youth that starts with a comprehensive assessment. This includes identified factors which contribute to that individual's risk to reoffend sexually and non-sexually.

The treatment plan is a living document which is updated at various points during the course of treatment. The treatment plan is designed to reflect and document progress and to be a significant resource for determining when treatment has been completed.

Youth should collaborate in the development of the treatment plan and identification of goals. To show their agreement with the treatment plan, the youth should sign the initial plan and any subsequent updates, and shall be provided a copy. Since information in the treatment plan can be useful in guiding supervision strategies, providers shall make a copy of the treatment plan available to the supervising officer, when created and updated.

The program shall utilize an evidence-based approach to creating the treatment plan so that it is supported by the professional literature to reduce recidivism and promote prosocial functioning and development of the youth. The treatment plan shall be designed to assist and guide youth to address any or all of the following:

1. Develop motivation for change and deeper engagement in the treatment process.
2. Develop increased understanding of the nature and role of thoughts, feelings, and behaviors in the development and maintenance of adaptive and maladaptive behaviors.
3. Increase knowledge of personal responsibility.
4. Develop and practice self-management skills.
5. Increase knowledge of healthy vs unhealthy relationships and begin to make personal decisions regarding relationships.
6. Explore interpersonal characteristics and promote the development of new interpersonal characteristics.
7. Explore empathy and develop increased perspective-taking.
8. Examine healthy and unhealthy behaviors and the effects of each on others.
9. Understand the effects of criminal behaviors on others.
10. Learn to challenge irrational thoughts
11. Learn how to thoughtfully weigh decisions before making them.
12. Learn and apply independent living skills.
13. Develop and implement practices to promote and preserve a healthy lifestyle
14. Develop a plan for self-monitoring and self-management to meet needs in a healthy way.
15. Appreciate the impact of sexual offending upon victims, their families, and the community.
16. Develop an individualized safety plan.

17. Manage and respond to emotions and impulses in positive, prosocial ways.
18. Develop healthy interpersonal skills, including communication, perspective-taking, healthy sexuality, and intimacy.
19. Develop prosocial image and activities.
20. When appropriate, counseling/education with parent(s)/guardian(s) to promote positive treatment goals for the youth and develop relevant skills.
21. Establish, maintain or expand positive support systems.
22. Identify and address any additional criminogenic need areas.

7. Treatment Modalities

Provider Agencies are expected to determine the modality of treatment based on the responsivity issues of the youth. The youth's assessment should on a case-by-case basis guide if individual treatment or group treatment will provide the best therapeutic environment for growth. The literature supports the use of individual therapy without a group component or group therapy in conjunction with individual therapy . Factors that impact group placement, include mental health issues, level of cognitive functioning, sexual or gender identity issues, or other individual factors. Not all youth will benefit from participation in group therapy. *If* the juvenile is clinically appropriate for group treatment, and groups are utilized, the following are recommended:

- a) Groups shall have no more than eight participants assigned per group.
- b) A group made up of between five and eight clients shall not be less than ninety minutes in length per group session
- c) Groups should be clustered by age, separating younger and older youth.
- d) Commingling male and female clients in the same group is not supported

Additional modalities, such as family therapy or skills based training should be determined on a case-by-case basis.

All treatment should have:

1. Sensitivity to cultural diversity – Services need to be provided in a language appropriate for the youth and their family/guardian. Translation services should be used as a last resort.
2. Procedure for modifications to modalities when working with individuals who have unique or special needs such as cognitive limitations, mental health issues, language or other barriers that may impede effective treatment
3. Consideration where applicable for victim reunification or contact with victims. The guiding criteria for this would be "best interests of the victim" as described elsewhere in this document. Reunification is not considered the default choice.

CASOMB recommends individuals identified as above-average or well-above average risk should receive a higher dosage of treatment than those at lower risk levels. The Collaborative Team shall determine frequency and duration of services. Justification for frequency and duration shall be clarified in the treatment plan based on individual characteristics.

CASOMB expects programs to utilize evidence based methods and modalities based on the client's needs and responsivity issues. The goal of such methods is to increase the youth's level of

psychosocial maturity and problem-solving, to reduce the risk of future harmful behaviors and to promote a positive and prosocial lifestyle. It is hypothesized that these different approaches likely all promote these outcomes. These include but are not limited to:

- Cognitive behavioral therapy (CBT)
- Strength-based interventions
- Pro-social life goals
- Trauma informed care
- Mindfulness meditation
- Dialectic behavior therapy (DBT)
- Brain based change and bio-feedback
- Eye movement desensitization and reprocessing (EMDR)
- Motivational Interviewing (MI)
- Behavioral conditioning
- Manualized treatment protocols emphasizing skill-building, problem-solving, and counseling methods, and includes methods to address the reduction of sexual and nonsexual recidivism.

A. Special Populations and Treatment Considerations

a. Females

It has been estimated that 5-8% of youth who sexually offend are females. Studies indicate that compared to males, female youth who offended sexually were likely to be younger and less likely to commit acts of rape. Female youth were more likely to be victims of sexual abuse and experienced more types of abuse. There may be higher levels of co-occurring psychiatric factors such as depression, anxiety, and suicidal behaviors. Also, the characteristics of female and males are different not only biologically, regarding sexual development and drive, but in terms of gender roles and socialization. Treatment approaches need to be adapted to these factors. Assessment of risk for sexual recidivism in females is challenging and a limited number of instruments are available.²⁴

b. Mental Health Issues

Literature has identified that youth who have committed a sexual offense have a high prevalence of co-occurring psychiatric and learning deficits or disabilities.. Many of these factors are treatable and can be improved. Identification of these factors as part of the assessment and facilitating evidence-based interventions to remediate these is an important goal. There is a significant literature supporting the effectiveness of interventions to remediate these factors. If not provided

²⁴ Righthand, S., Welch, C. (2001). *Juveniles Who Have Sexually Offended: A Review of the Professional Literature*. (Report No. 184739). Office of Juvenile Justice and Delinquency Prevention. <https://www.ojp.gov/pdffiles1/ojjdp/184739.pdf>

adequate assessment and treatment, these factors may contribute to recidivism. Relevant research is described below.

The Commission on Youth, Commonwealth of Virginia (2011), reports up to 80% have a diagnosable psychiatric disorder. Thirty to 60% exhibit learning disabilities and academic dysfunction.

ATSA Guidelines (2017) notes research has identified a higher incidence of mental health related disorders in juveniles with harmful sexual behaviors. The ATSA guidelines discuss a large meta-analysis with prevalence rates as follows:

- 69% at least one mental disorder
- 51% Conduct Disorder
- 44% at least two mental disorders
- 30% at least one substance use disorder
- 18% Anxiety Disorder
- 14% ADHD
- 9% Affective Disorder
- 8% PTSD

Epperson (2006) reported 25% of these youth had a diagnosed self-regulation disorder including ADHD, Impulse Control Disorder, Conduct Disorder, or Oppositional Defiant Disorder. Twenty percent (20%) had a diagnosis of an affective disorder including depression, anxiety, or bipolar disorder. Twenty-nine percent (29%) had a history of special education status. In Epperson's study each of these factors approximately tripled the risk of sexual recidivism.

c. Intellectual Disability

According to the DSM 5, about 1% of all youth in the general population have a diagnosis of intellectual disability and 2% have a diagnosis of autistic spectrum disorder. The number of boys with autistic spectrum disorder is four times greater than girls in the general population.²⁵ Youth with these characteristics likely have different victim and offense characteristics, and factors that motivated sexual offenses. Learning styles for these populations are distinct from the general population and it is important to identify areas of relative strength and treatment methods. They may have distinct patterns of judgment and insight that both contributed to offending and should be targeted in treatment. Youth with intellectual disabilities may have greater vulnerability to mood problems and suicidal ideation. Special adaptations regarding assessment and treatment should be implemented with these youth.²⁶

²⁵ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

²⁶ National Institute of Mental Health. (2022). Autisim Spectrum Disorder (ASD). Retrieved October 20, 2022, from <https://www.nimh.nih.gov/health/statistics/autism-spectrum-disorder-asd#:~:text=Across%20the%20CDC%20surveillance%20sites,all%20racial%20and%20ethnic%20groups.>

d. Emerging Adults, age 18-25

Emerging adulthood is a developmental stage that occurs between the ages of eighteen and twenty-five. Emerging adulthood is often characterized by instability and as an age of exploration, during which drug, alcohol and sexuality experimentation are common. Emerging adulthood provides an increased level of freedom and less social controls than youth between the ages of 13 and 17. The risks and needs of this age group are different from adolescents, yet, this group is also different than adults and is often described as the emerging adulthood gap. This influences behavior and often the feeling of being “in between”.²⁷

California allows for youth to be sentenced under the juvenile system until the age of 25. This poses a unique challenge in assessing risk and providing appropriate treatment to a population that committed an offense under the age of 18, but is now between the ages of 18 and 25. It is important to acknowledge the differences in the risks and needs of this age group while still recognizing that the offense occurred under the age of 18.

Successful treatment and outcomes are best when approaches are tailored based on individual factors, risk level and interventions that target changeable risk factors. Therefore special guidance is required in recognition that emerging adults falls between the researched populations of juveniles who committed offenses under the age of 18 and individuals who committed offenses as an adults. To achieve positive outcomes with emerging adults, it is important to determine where the youth falls on the developmental continuum, their associated treatment needs and recidivism risk.

There is an identified gap for this population with risk assessment tools as most are validated on either a juvenile sample, with some going up to age 19 or an adult sample where the offense was committed at 17 or above depending upon the tool. Questions remain about which assessment strategies are most reliable given the uncertainties about reliability and validity with this specific population.

The compendium of dynamic risk factors for adults and youth with sexually abusive behavior, framed within the context of developmental goals, challenges, and characteristics of the emerging adulthood stage are grounding points for intervening with this population. This framework also allows for an acknowledgement that the difficulties faced by this population are similar in many ways to the challenges and difficulties faced by their non-justice involved peers as part of the normative life course.²⁸

²⁷ Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55(5), 469–480. <https://doi.org/10.1037/0003-066X.55.5.469>

²⁸ Arnett, J. J. (2000).

e. Family Therapy and Parenting

Research has identified that family functioning and parenting have been identified as an important factor in youth offense behavior and treatment success.²⁹ Epperson (2006) reported 26% of juveniles who sexually offended had severe difficulty relating to parents and 26% relating to siblings. These factors approximately tripled sexual recidivism. Family and parenting risk factors include: low parental monitoring, high conflict, and low affection contribute to increased recidivism. Treatment approaches that address improved family functioning have better outcomes and is associated with decreased sexual and general criminal recidivism.³⁰

The focus for some families may be improved parentings skills, while others may need family therapy to identify and address problematic family dynamics. The motivation and availability of families differ for treatment involvement. Developing systematic strategies to include families in treatment is important.³¹

f. Reconciliation

For some youth, the victim of the offense was a younger sibling or child in the household. One study for example found that 43% of young adults who were sexually abused as children were victims of sibling sexual abuse.³² There may be similar situations such as the offense occurring in a separate household with a half-sibling or other relative. As a result, the siblings are usually separated, with the offending sibling placed outside the residence where the victim resides. This is to ensure both the physical safety of the victim and to create a safe environment. There may be circumstances where reintegration of the offending youth into the family residence is appropriate. The primary consideration is what are the interests and needs of the victim. Typically such a process takes place after considerable time and treatment. It usually requires not only the offending youth, but the victim separately to be in counseling and therapy. It requires approval of the courts, probation officer, and if present, the child welfare worker. There should be a determination and recommendation from the victim's therapist, in consultation with the parent of the victim, that such a reunification is desirable and in the best interests of the victim. The wishes of the youth or parent, and practical or financial considerations should not be the primary concern. This process often involves the victim and family making sufficient progress in treatment where such a step is practically and emotionally desirable. Likewise, it requires that the offending youth's therapist believes that the youth does not pose a significant risk to the victim, others, or generally, and that

²⁹ Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*(1), 26–37. <https://doi.org/10.1037/a0013035>

³⁰ Borduin, Schaeffer, & Heiblum, 2009

³¹ Bonner, B.L. *Take Action Support for Families of Adolescents with Illegal Sexual Behavior*. Safer Society Press. <https://safersocietypress.org/store/taking-action-adolescents-download/>

³² Queensland Government. (2022). *Child Safety Practice Manual When a child is sexually abused by another child or a sibling*. [https://cspm.csyw.qld.gov.au/practice-kits/child-sexual-abuse/working-with-children-who-display-sexually-reactiv/seeing-and-understanding/when-a-child-is-sexually-abused-by-another-child-#:~:text=A%20study%20by%20the%20NSPCC,abuse%20\(Stathopoulos%2C%202012\)](https://cspm.csyw.qld.gov.au/practice-kits/child-sexual-abuse/working-with-children-who-display-sexually-reactiv/seeing-and-understanding/when-a-child-is-sexually-abused-by-another-child-#:~:text=A%20study%20by%20the%20NSPCC,abuse%20(Stathopoulos%2C%202012))

they can manage the reunification. This involves the use of concrete steps in family meetings and agreement about arrangements that occur over time as part of a deliberate plan. Published guidelines and protocols can aid this process.³³

8. Treatment Content and Completion

“Successful treatment completion” is defined as having “demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan” at the time of release from active treatment.³⁴

Treatment should address several issues, including factors affecting both sexual and nonsexual recidivism, and co-occurring psychiatric factors. Separately additional recommendations can be made to school districts regarding appropriate educational accommodations through the development or modification of an Individualized Education Plan (IEP) or 504 plan. Treatment approaches should be trauma-informed and culturally sensitive. Manualized treatment protocols emphasizing skill-building, problem-solving, counseling methods, and includes methods to address the reduction of sexual and nonsexual recidivism can be helpful. Referral of the youth for treatment of mental health factors may be necessary.

Treatment for sexual recidivism:

The same criteria for identifying treatment methods for general recidivism are relevant for programs for youth who offended sexually. These treatment programs often include content related to sexual behaviors, understanding of causal factors relating to sexual offenses, and teaching skills and strategies to prevent future problems. Regarding evidence-based programs that meet these criteria, only one has been identified: Multisystemic Therapy (MST). MST has an extensive research showing positive outcomes.³⁵ Other programs have also been designed that show promising results. Kettrey & Lipsey (2018) in their study of 9 programs with adequate methodological characteristics found that specialized programs to treat youth are not "...more effective for reducing sexual recidivism than general treatment as usual in juvenile justice systems."³⁶ Quality of the treatment program also has a significant impact on the outcomes of treatment. See appendix F for more information.

³³ Chaffin, M. (n.d.). *Reintegrating Juvenile Offenders Into the Family*. Center on Child Abuse and Neglect, Oklahoma Health Sciences Center: University of Oklahoma.

<https://nic.unlv.edu/pcan/files/Reintegrating%20juvenile%20offenders-Mark%20Chafin.pdf>

³⁴ Association for the Treatment of Sexual Abusers (ATSA). (2014). *ATSA Adult Practice Guidelines*. Beaverton, OR.: Association for the Treatment of Sexual Abusers.

³⁵ Borduin, Schaeffer, & Heiblum, 2009

³⁶ Kettrey, H. H., & Lipsey, M. W. (2018). The effects of specialized treatment on the recidivism of juvenile sex offenders: A systematic review and meta-analysis. *Journal of Experimental Criminology*, 14(3), 361–387.

<https://doi.org/10.1007/s11292-018-9329-3>

Treatment for general recidivism:

A large literature exists regarding effective treatment methods for probation youth generally.³⁷ Research has emphasized the characteristic of programs predicting effectiveness, rather than specifically identified programs. Programs should incorporate characteristics of effective treatment models which includes the following:³⁸

1. The risk level and needs of the target population are assessed using reliable measures.
2. A treatment approach addresses the risk level and needs of the target population and includes a sufficient amount of treatment to be effective.
3. The treatment approach uses social skill-building, problem-solving, and counseling approaches.
4. The treatment method is manualized to reliably administer it.
5. Training and ongoing supervision and assessment is done regarding fidelity to the treatment method and quality of implementation.
6. Quality assurance checks are part of the implementation of the method.
7. Reliable outcome pre/post measures are used to assess treatment effectiveness.

Research findings indicate that generally well-designed programs for this population that are faithfully implemented with high fidelity and focus on skill-building, problem-solving, and counseling are likely to be effective. Locally developed programs can be as effective in reducing recidivism as more well-known published curriculum models.

Model programs identified as effective in reducing general recidivism with both the general population and also showing effectiveness with youth include but are not limited to the following:

- a) Multisystemic Therapy³⁹
- b) Aggression Replacement Training⁴⁰
- c) Cognitive-Behavioral Interventions – Core (University of Cincinnati Criminal Justice Institute)⁴¹
- d) Free Your Mind (University of Cincinnati criminal Justice Institute)⁴²

³⁷ Lipsey et al., 2010

³⁸ Ralph, N. (2017, May 12). Evidence-Based Practice for Juveniles in 2017 [Blog post]. Retrieved from <https://blog.atsa.com/2017/05/evidence-based-practice-for-juveniles.html>

³⁹ Borduin, Schaeffer, & Heiblum, 2009

⁴⁰ Amendola, M., & Oliver, R. (2010). Aggression Replacement Training stands the test of time. *Reclaiming Children and Youth*, 19, 47-50.

⁴¹ Group Interventions. (n.d.). Cech.uc.edu. Retrieved October 16, 2022, from

<https://cech.uc.edu/about/centers/ucci/products/interventions/group-interventions.html>

⁴² Pealer, J.A., Latessa, E.J., & Winesburg, M. (2002). *Final Report: Ohio RSAT Outcome Evaluation*. National Institute of Justice. https://www.ohio.gov/content/dam/ohio-state/government/department-of-public-safety/docs/reports/project_reports/RSAT_Summary.pdf

- e) Other models may be considered including Thinking for a Change,⁴³ and Moral Reconation Therapy.⁴⁴

Strengths:

The ATSA Adolescent Guidelines (2017) recommends that practitioners design interventions that promote prosocial goals by building on existing strengths. (pg 38). Worling & Laughton (2015) identified a medium effect size from areas of strengths regarding predicting sexual recidivism for juveniles. Factors such as interpersonal strength, family involvement, school functioning, and affective or emotional strength contributed to desistance from sexual recidivism. This research and development of relevant instruments reflects a major change in this field. This change addresses strength factors for the youth as being a significant modifiable risk factor which if addressed by treatment providers would contribute to decreased sexual recidivism. Current practices describe the importance of identifying current strengths and potential strengths, and to build and support those within the natural ecology of the family and community while being respectful and supporting cultural and language factors.

Healthy Sexuality:

The ATSA Adolescent Guidelines (2017) recommends that practitioners design interventions to support healthy sexual expression and appropriate sexual regulation. Deficits in this area can be addressed through structured, developmentally and culturally sensitive curriculum. Curriculum should include: characteristics of a healthy sexual relationship, normative sexual behavior, sex related biology of the human body, safe sex practices, identification of and intervention for sexual harassment, and interventions for sexual violence.⁴⁵ ATSA's Adolescent Guidelines also note that practitioners need to focus on creating appropriate opportunities for practicing appropriate "social, courtship, and dating skills."⁴⁶ Treatment strategies should assist with problematic and potentially harmful sexual arousal, and appropriate restrictions from situations that may increase these problematic reactions.

Step-Down

Current research suggests that youth in residential settings should be stepped down to a less restrictive setting, such as community care as soon as clinically appropriate. The decision to step

⁴³ Bush, J. C., Glick, B., & Taymans, J. M. (1998). *Thinking for a change: Integrated Cognitive Behavior Change Program*. National Institute of Corrections.

⁴⁴ Burnette, K. D., Swan, E. S., Robinson, K. D., Woods-Robinson, M., & Little, G. L. (2004). Treating youthful offenders with Moral Reconation Therapy: A recidivism and pre- posttest analysis. *Cognitive-Behavioral Treatment Review*, 3(4), 14-15.

⁴⁵ California Department of Corrections and Rehabilitation - Division of Juvenile Justice Sexual Behavior Treatment Program (2010), unpublished.

⁴⁶ ATSA, 2017

a youth down should be made through a formal assessment of risk and need, including progress in treatment. Hunter, John A. (2012).⁴⁷

Conducting baseline assessments and ongoing assessments are necessary for monitoring treatment progress and adjusting treatment plans. This will allow for successful tracking of progress and progression towards a step-down program. Risk assessments prior to stepping down from a residential program or discharge from community-based programs are necessary to assess which treatment needs have been resolved and what additional resources and/or supportive resources are needed.⁴⁸

Research also suggests that the assignment and assessment of treatment goals should be connected to known risks to reoffend. Treatment completion should not be determined by factors identified to be unlikely to contribute to re-offense. These factors include items such as denial of sexual offending and low victim empathy.⁴⁹

Effective planning is important to a successful step-down and services should be put into place prior to the actual step-down. Planning should be a collaborative process that involves the youth, his or her family when appropriate, probation, the residential treatment provider, and community provider, if care is transitioning.⁵⁰

9. Other Documentation

Each provider agency shall maintain appropriate case documentation. These include the following: clinical records of each therapeutic contact, containment team and other collaborative team contact, notes documenting case management activities outside of the therapeutic contact, periodic progress reports, a written discharge summary, statement of successful treatment completion and any other legally required or clinically indicated written records.

All provider agencies, agency employees, such as administrative and IT personnel and providers who have access to criminal record information must meet FBI and California Department of Justice requirements by taking and passing the NexTEST exam. This must be renewed every two years. Failure to renew will lead to suspension of provider agency or provider certification, or both. Email CASOMB staff at casomb@cdcr.ca.gov for instructions.

Clinical notes for each therapeutic contact must occur. These shall include information such as client name, treatment provider name, date, time, duration of contact, client level of participation, progress towards treatment goals, treatment homework assignments, topics discussed or any risk management concerns.

⁴⁷ Hunter, J.A. (2012). Management and Treatment Methods. In E.P. Ryan, D.C. Murrie, & J.A. Hunter (Eds.), *Juvenile Sex Offenders: A Guide to Evaluation and Treatment for Mental Health Professionals*.

⁴⁸ Righthand, S., Vincent, G., & Huff, R.M. (2017). Assessing Risks and Needs,. In S. Righthand & W.D. Murphy (Eds.), *The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended*. Safer Society Press: Global Institute of Forensic Research.

⁴⁹ Rich, P. (2015). The Assessment of Risk for Sexual Re-offense in Juveniles Who Commit Sexual Offenses. *Sex Offender Management Assessment and Planning Initiative* (Report No. 251950). U.S. Department of Justice Office of Justice Programs. https://sgc.wa.gov/sites/default/files/public/SOPB/meetings/2021/somapi_full_report.pdf

⁵⁰ Hunter, 2012

Written progress reports shall memorialize the individual client's involvement in and advancement through a program. Frequency and content of any such reports should be provided to the supervising officer or agent and discussed with the supervising agency.

As each youth exits treatment, whether because treatment has been completed or for any other reason, a written discharge summary shall be prepared. This summary should include information such as the youth's participation in the treatment program, progress on goals identified in the treatment plan, strengths, and strategies to manage sexual and non-sexual risk. The reason for leaving treatment should also be stated. The discharge summary shall be provided to the probation officer.

Appendices

A. Brain, Behavioral, and Physical Development of Adolescents

Adolescence is a period of rapid physical, sexual, and brain development. For example, the grip strength of males triples from ages 10 to 18, and their weight more than doubles.⁵¹ Testosterone affects not only physical and sexual development but also sexual drive and aggressive behaviors. Testosterone levels quadruple during this time period.⁵² Secondary sexual characteristics and reproductive abilities develop rapidly.

Adolescence is a period of brain development and related behavioral maturity regarding prosocial reasoning. While the size of the brain does not change from ages 10 to 25, the configuration of the brain pathways does. The brain is the last major organ in the body to fully develop. An area of significant development is the connections for communication for various parts of the brain. This involves in part myelination or the wrapping of brain cells with insulating materials which facilitate transmissions.⁵³

The last part of the brain to develop in this way is the front part, the frontal lobes. The frontal lobes are important for judgment, impulse control, decision-making, and empathy.⁵⁴ Slowed development in this area is complemented by a rapid increase of drive and motivation to do risky or rewarding behaviors without giving adequate weight or consideration to possible adverse consequences.⁵⁵ Many problematic behaviors have the highest incidence rate during adolescence, directly connected to brain development. In all cultures youth ages 10 to 25 have the highest rate of accidents. For example, motor vehicle injuries to others where the driver was less than 25 years old are about 3 times as high compared to older age groups.⁵⁶ The highest rates for nonviolent crimes are ages 16 and 17, and are over 3 times higher than for those over 30 years of age.⁵⁷ Being on probation is strongly related to psychosocial and prosocial immaturity for adolescents.⁵⁸ For a given age, those who are less psychosocially mature are more likely to be on probation for any offense. Harmful sexual behaviors by adolescents toward children have its highest incidence at

⁵¹ Ferreira, A.C.C., Shimano, A.C., Mazzer, N., Barbieri, C.H., Elui, V.M.C., & Fonseca, M.R. (2011). Grip and pinch in healthy children and adolescents. *Acta Ortop Bras.* 19(2); 92-7.

⁵² Best, B. (n.d.). Mechanisms of Aging. <https://benbest.com/lifeext/aging.html>

⁵³ Jensen, F.E., & Nutt, A.E. 2015

⁵⁴ Jensen, F.E., & Nutt, A.E. 2015

⁵⁵ Steinberg, L. (2015). *Age of opportunity: Lessons from the new science of adolescence*. Mariner Books.

⁵⁶ Tefft, B.C. (2017). *Rates of Motor Vehicle Crashes, Injuries and Deaths in Relation to Driver Age, United States, 2014-2015* (Research Brief). Washington, D.C.: AAA Foundation for Traffic Safety.

⁵⁷ Canadian Centre for Justice Statistics. (2014). Youth Crime in Canada, 2014.

<https://www150.statcan.gc.ca/n1/pub/85-002-x/2016001/article/14309-eng.htm>

⁵⁸ Stams, G. J., Brugman, D., Deković, M., van Rosmalen, L., van der Laan, P., & Gibbs, J. C. (2006). The moral judgment of juvenile delinquents: a meta-analysis. *Journal of abnormal child psychology*, 34(5), 697–713.

<https://doi.org/10.1007/s10802-006-9056-5>

ages 13 and 14.⁵⁹ Probation involved youth who psychosocially mature are less likely to recidivate which suggests that strategies to promote this maturity should be a priority.⁶⁰

B. Recidivism, Typologies, & Co-occurring Conditions

Rapid changes in brain development and increased psychosocial maturity in adolescents appears connected with recidivism rates for this population. Since 2000 sexual recidivism rates for Youth are estimated to be 2.75% and general criminal recidivism is 30.0%.⁶¹ Beliefs that sexually harmful behaviors in adolescence persist at high rates into adulthood are not supported by available evidence. Likewise, sexual interest in children does not persist for adolescents.⁶² Bonner (2012) has described early adolescence, as a high-risk, transitory developmental period for committing harmful sexual behaviors.⁶³ Pullman and Seto (2012) note that most youth are "generalists" who engage in a variety of delinquent behaviors, rather than "specialists" engaging primarily in sexually harmful behaviors.⁶⁴ Recidivism rates for sexually harmful behaviors is comparable to similar behaviors in the general adolescent population, and one study identified that 4.8% of male and 1.3% of female adolescents engaged in coercive sexual acts.⁶⁵

Research indicates there are both similarities and differences between juveniles who sexually offended and the general probation population. Both groups have relatively higher rates of family separations, substance abuse, criminality, and learning challenges. Youth are more likely to have higher rates of physical and sexual abuse, low self-esteem, social isolation, exposure to pornography, and poor social skills. Youth are also likely to have higher rates than the general population regarding IEPs, ADHD, substance use, trauma history, and PTSD. In turn, sexual abuse, physical abuse, dysfunctional families, learning problems, or ADHD or related disorders, if present, are associated with triple the risk of sexual recidivism.

In summary, conclusions from this research indicate treatment and disposition planning for youth needs to be designed with the awareness that recidivism is relatively low, that nonsexual recidivism is about 10 times higher than sexual recidivism, and that there is a high level of co-occurring psychiatric factors (family, ADHD, trauma, substance use, etc.). Targeting treatment of factors to reduce general recidivism and also co-occurring psychiatric factors along with a sexually-focused curriculum is essential to promote prosocial development of these youth and decrease recidivism.

⁵⁹ Canadian Centre for Justice Statistics. (2012). Police-reported sexual offences against children and youth in Canada. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14008-eng.htm#a8>

⁶⁰ Steinberg et al. 2015

⁶¹ Caldwell, 2016

⁶² CCOSO, 2013

⁶³ Bonner, B. (2012). Don't shoot: We're your children. What we know about children and adolescents with sexual behavior problems. Retrieved February 20, 2017, from Boy Scouts of America, <http://www.scouting.org/filestore/nyps/presentations/Children-with-SexualBehavior-Problems-Bonner.ppt>

⁶⁴ Pullman, L., & Seto, M.C. (2012). Assessment and treatment of adolescent sexual offenders: Implications of recent research on generalist versus specialist explanations. *Child Abuse & Neglect*, 36(3), 203-209.

⁶⁵ Borowsky, I. W., Hogan, M., & Ireland, M. (1997). Adolescent sexual aggression: Risk and protective factors. *Pediatrics*, 100(6). <https://doi.org/10.1542/peds.100.6.e7>

C. Juvenile Court Transfer

Under current law, a prosecutor may make a motion to transfer a minor who is 16 or 17 years of age from juvenile court to a court of criminal jurisdiction in any case in which the minor is alleged to have committed a felony. Most youth would not be considered routinely for such a transfer, and this is usually expected to apply only in extraordinary situations. A prosecutor may also make a motion to transfer a minor who is alleged to have committed an offense listed in Welf. & Inst. Code § 707(b) from juvenile court to a court of criminal jurisdiction if the offense was committed while the minor was 14 or 15 years of age but the minor was not apprehended prior to the end of juvenile court jurisdiction.

Once the prosecution motion is filed, the juvenile court shall order the probation officer to submit a report (a social study) on the “behavioral patterns and social history” of the minor. The report is to include any statement offered by the victim. Following receipt and consideration of the probation report, and of any other relevant evidence that the prosecution and the minor choose to submit, the court must decide whether the minor should be transferred to a court of criminal jurisdiction or remain in juvenile court.

In making its decision, the court must consider specified criteria including:

- a) **The degree of criminal sophistication exhibited by the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the minor’s age, maturity, intellectual capacity, and physical, mental, and emotional health at the time of the alleged offense, the minor’s impetuosity or failure to appreciate risks and consequences of criminal behavior, the effect of familial, adult, or peer pressure on the minor’s actions, and the effect of the minor’s family and community environment and childhood trauma on the minor’s criminal sophistication;
- b) **Whether the minor can be rehabilitated prior to the expiration of the juvenile court’s jurisdiction.** The juvenile court may give weight to any relevant factor, including, but not limited to, the minor’s potential to grow and mature;
- c) **The minor’s previous delinquent history.** The juvenile court may give weight to any relevant factor, including, but not limited to, the seriousness of the minor’s previous delinquent history and the effect of the minor’s family and community environment and childhood trauma on the minor’s previous delinquent behavior;
- d) **Success of previous attempts by the juvenile court to rehabilitate the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the adequacy of the services previously provided to address the minor’s needs; and,
- e) **The circumstances and gravity of the offense alleged to have been committed by the minor.** The juvenile court may give weight to any relevant factor, including, but not limited to, the actual behavior of the person, the mental state of the person, the person’s degree of involvement in the crime, the level of harm actually caused by the person, and the person’s mental and emotional development.

The prosecutor has the burden to show, by a preponderance of the evidence, that the minor should be transferred. If the juvenile court orders a transfer to a court of criminal jurisdiction, the court must recite the basis for its decision in an order entered upon the minutes. (Assembly Bill 2361, currently pending, would require the court to find by clear and convincing evidence that the minor is not amenable to juvenile court rehabilitative efforts before a person could be transferred to criminal court. The court would also be required to recite the basis and include the reasons for its transfer decision). The statutory criteria the court evaluates in § 707(a)(3)(A)-(E) need to be viewed through the lens of the neuroscience and adolescent development. Overall trauma, i.e. exposure to violence, dysfunctional family and community environment, abuse of any kind, etc... are clearly mitigating factors for several of the statutory criteria.

While the current version of the statute doesn't use "amenability" to treatment as a criterion for determining transfer, it is likely to be the *main* factor by the end of this legislative session. Dr. Michael Caldwell, Psy.D. refers to "treatability issues" when considering the potential successful treatment of a youth who remains in juvenile court. Some of those issues include mental illness, verbal skills, taking responsibility for one's actions, general concern/care for others, family support and ability to supervise appropriately, and positive peer and community support. Presenting evidence of these positive, protective factors can provide further evidence of amenability to juvenile court interventions.

Considerations regarding these factors should be made with appropriate qualifications. For example, the research of Steinberg, Cauffman, and others, points out for example that most probation involved youth, even those with severe charges, do not go on to reoffend. In one study, only 38% of youth identified with serious criminal traits, described as psychopathy, continue to be so classified only two years later. Youth who psychosocially matured were less likely to reoffend or to have psychopathic traits. Opportunities to promote and provide treatment for psychosocial and developmental maturity are important consideration. (see Ralph, N, "Neuropsychological and Developmental Factors in Juvenile Transfer Hearings: Prosocial Perspectives." Journal of Juvenile Law & Policy, 2020).

D. Defining Scientifically Valid Instruments

Sexual recidivism risk measures: Scientifically valid instruments assessing sexual recidivism should be included. Characteristics of valid instruments include:

1. adequate interrater reliability,
2. a structured curriculum to train individuals in their use,
3. the ability of instruments to predict recidivism with at least a moderate effect size,
4. multiple replications with large sample sizes, and
5. replication by researchers other than the authors of the instruments.

E. Importance of Government Case Tracking

It is recommended that counties and the state develop a method to track case information regarding number of cases, charges, demographic information (including age and ethnic group), treatment placement and duration, and outcomes such as percent completion of treatment, and sexual and nonsexual recidivism. Management on the county basis would be improved by such information. Collecting this data on the statewide level would also assist with rational policy development in this area. At present no such system exists at a county or state level. Ideally such information would be presented to the CMT on a monthly basis to assist with case tracking.

F. Defining a Quality Treatment Program

Baglivio et al. 2018⁶⁶ evaluated 56 residential programs for probation youth in Florida. In summary the authors note, increased treatment quality was associated with decreases in the odds of reincarceration, reoffending, and reconviction. These results support the hypothesis that the quality of the interventions delivered in a residential setting can positively affect subsequent outcomes through decreased recidivism rates.

Quality and fidelity of programs matter, not just the type of program. Program factors associated with better outcomes included adequate therapist training, a manualized treatment protocol, observed adherence to treatment models, internal fidelity monitoring, corrective action with problem situations, and evaluation of the effectiveness of the facilitator. Ideally, program outcome information would be used to modify methods to achieve greater effectiveness and assist with continuous quality improvement.

An important component is "building in" treatment progress measures, such as the one described by Righthand and associates,⁶⁷ and on a program level, to track treatment outcomes, including, but not limited to, sexual and nonsexual recidivism.

⁶⁶ Baglivio, M.T., Wolff, K.T., Jackowski, K., Chapman, G., Greenwald, M.A. and Gomez, K. (2018), Does Treatment Quality Matter?. *Criminology & Public Policy*, 17: 147-180. <https://doi.org/10.1111/1745-9133.12338>

⁶⁷ Prentky, R.A., Kang, T., Worling, J., & Righthand, S., (2020). *Final Report Development and Implementation Project for the Youth Needs and Progress Scale (YNPS)*. U.S. Department of Justice.

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