The Maryland
Department of Juvenile Services

Task Force Report

Re: Juvenile Sex Offenders

Every child will become a self-sufficient productive adult.

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Kenneth C. Montague, Jr.
Secretary

July 2005

Executive Summary
Maryland Department of Juvenile Services
Task Force Report on Juvenile Sex Offenders

In 2003 a group of DJS staff recognized the disparity in services and service providers for sex offending youth from differing jurisdictions around the State. In order to more fully understand the risks and needs posed by juvenile sex offenders (JSO) and DJS' ability to deal with these youth, this group of DJS staff came together along with other juvenile justice stakeholders and formed a task force. With ongoing consultation from Dr. Barbara Bonner, Administrator for the National Center on Sexual Behavior of Youth, the task force focused on:

- Learning the current nature and extent of Maryland's juvenile sex offending;
- Researching "state of the art" practices concerning JSO assessment and treatment;
- Identifying key areas within the juvenile justice system for improvement; and
- Developing appropriate evaluation criteria and effective services.

Listed below is a summary of the task force's major findings:

- Treatment for youthful sex offenders holds promise. When Maryland youth who offend sexually were tracked for two years following release from probation or placement, recidivism rates for sex offenses were significantly lower (4.1% and 10.2%, respectively) than for any other re-offense (19.2% and 19.3%, respectively).

- Nationally and locally there is a lack of research on treatment effectiveness according to different offenses and various types of intervention.

- DJS does not have an administrative staff responsible for overseeing policy, programming, training and quality control matters for JSO programming.

- Currently, private clinicians and DJS staff are not mandated to meet basic, consistent requirements prior to providing services to JSOs.

- Statewide DJS lacks the tools or resources to provide differential assessment based on different levels of offenders.

- Jurisdictions differ in their access to community based intervention as well as secure and residential treatment resources. There is also disparity in the quality of programs for sex offending youth.

- The task force noted two promising programs:
    - Baltimore County Juvenile Sex Offender Treatment; and
    - Norfolk (Virginia) Juvenile Sex Offender Program.

In addition, the task force generated the following protocols:

- Protocol for the Assessment of Juvenile Sex Offenders.

    - Defines two-tiers of assessment at the Case Manager Specialist (CMS) and clinician levels;
    - Clarifies what tools CMS and clinicians are to use;
    - Standardizes subject matter to be examined; and
    - Prescribes presentation format for assessments.

- Protocols for Supervising Juvenile Sex Offenders.
    - Identifies key components of supervision.
        - Interagency collaboration,
        - Specialization,
        - Treatment service plans,
        - Family involvement, and
        - Aftercare.
    - Establishes standards for effective supervision.

- Treatment of Juvenile Sex Offenders.
    - Sets forth standards for effective treatment of youthful sex offenders; and
    - Clarifies collaboration between DJS staff and treatment providers.

- Qualifications and Training for Clinicians and DJS Staff Who Provide Direct Services to Adolescents Who Offend Sexually:
    - Defines qualifications for clinicians who perform evaluation and treatment; and
    - Establishes parameters for education, experience and continued education for clinicians and DJS staff.

All of the protocols are appended to the task force report.

Finally, the Task Force on Sexual Offenders made seven recommendations:

- Create a position of Director of Treatment Services for Sex Offending Youth to oversee policy, programming, training and quality control matters for JSO programs.

- Require clinicians and DJS staff to meet basic professional requirements prior to providing services.

- Conduct further study of treatment effectiveness according to different offenses and various types of intervention.

- Implement differential assessment based on different levels of offenders.

- Establish in each jurisdiction an array of community based intervention and equal access to secure and residential treatment resources.
- Study two promising programs toward replication:

  - Baltimore County Juvenile Sex Offender Treatment; and
  - Norfolk (Virginia) Juvenile Sex Offender Program.

- Develop Requests for Proposals to procure all services/programs for JSO. This will insure consistency and quality of treatment.

The next steps needed toward implementation of the recommendations are:

- Secure Executive staff approval of the Sex Offender Task Force Report;
- Establish a DJS web link and place the Sex Offender Task Force Report on that site under publications;
- Continue the task force work to assist and support DJS and the Director of Sex Offending Services in implementation of the recommendations; and
- Designate a DJS executive to oversee implementation of the recommendations, pending hire of the “Director” position, and a review date should be set for assessing progress.

Maryland Department of Juvenile Services
Report of the Task Force on Juvenile Sex Offenders

November 3, 2004

In the fall of 2003, a group of Department of Juvenile Services' (DJS) managers and other Maryland juvenile justice system stakeholders formed a task force to examine services for juvenile sex offenders (JSOs). Then DJS Deputy Secretary Vickie Colter asked Delmas Wood, DJS Assistant Secretary, to chair this Task Force, and soon Christie Johnson, DJS Director, Program Development agreed to serve as co-chair. From the beginning, the task force was fortunate to have the consulting services of Dr. Barbara Bonner, Center Administrator for the National Center on Sexual Behavior of Youth.

The Task Force included both DJS and other juvenile justice and clinical professionals:
Gwen Brooks, DJS Confinement Review Coordinator
Phyllis Burke, Program Coordinator, Baltimore County Juvenile Sex Offender Treatment Program
Patricia Flanigan, DJS Assistant Area Director, Area I
Deborah Hermann, Assistant State's Attorney, State's Attorney for Baltimore City
Robert Jones, DJS Area Director, Area II
Elizabeth Lewis, Assistant Public Defender, Juvenile Services Division, Office of the Public Defender
Nicole Mills, DJS Case Management Specialist, Area IV
Vicky Mitchell, DJS Area Director, Area V
Melissa Nolan, Director, Juvenile Services Division, Office of the Public Defender,
Mary Louis Orth, DJS Director of Placement Services
Cynthia Ruiz Theoharris, DJS Resource Coordinator, Area III
Paul Waldman, DJS County Supervisor, Area II
Joyce Wright, Division Chief, Juvenile Courts Division, Office of the State's Attorney for Baltimore City

The Task Force focused its efforts on:

- Becoming informed of the current nature and extent of juvenile sexual offending in Maryland.
- Researching "state of the art" protocols for the assessment and treatment of JSOs.
- Identifying key areas within the juvenile justice system for improvements.

This report includes:

- Recommendations of the Task Force
- DJS data
- "What Research Shows About Adolescent Sex Offenders," from the National Center on Sexual Behavior of Youth
- Assessment of Juvenile Sex Offenders
- Treatment of Juvenile Sex Offenders

- Supervising Juvenile Sex Offenders
- Credentials and Training for Clinicians and DJS Staff Who Provide Direct Services to Adolescents Who Offend Sexually.

Maryland Data on Juvenile Sex Offenders

- In calendar year 2003, DJS received 1,054 sex offense complaints on 655 different youth. The highest number of complaints was for "Sex Offense 4th Degree" (336), followed by "Sex Offense 2nd Degree" (189)
- These offenses were spread over the entire State, with Area V (Prince George's, Anne Arundel, Charles, Calvert, St. Mary's) showing the greatest volume (327)
- About 80% of sex offenses in FY 2003 were sent to the State's Attorney for the filing of a delinquency petition.

According to a survey of DJS case managers in 2004:

- There were 472 JSOs under supervision to 168 different workers.
- 195 were in residential placement outside of their home.
- 275 were living at home in the community.
- Of those in residential placement, the highest numbers were at Fairbridge Treatment Center (38), New Directions (26), Woodbourne Center (22), and the Pines Treatment Center in Virginia (17) [data from ASSIST, 3/5/04).

Sex Offender Re-adjudication Recidivism Rates for FY 2001 Placement Releases

Method: Youth who were released from committed (including secure and non-secure residential) programs in FY 2001 formed the base group. All these youth were followed up from the date of their release for 2 full years.

Results: The total sex offenders released during FY 2001 was 88 Youths.
and their re-adjudication rate was 19.3%, i.e., 17 out of 88 youth were re-adjudicated for any offense; and

The re-adjudication rate for another sex offense was 10.2%, i.e., 9 out 88 youth were re-adjudicated for a repeat sex offense.

Sex Offender Re-adjudication Recidivism Rates for FY 2001 Probation Releases

Method: Youth who were released from probation assignment in FY 2001 formed the base group. All these youth were followed up from the date of their release for 2 full years.

Results: The total sex offenders released during FY 2001 was 146 Youths.
and their re-adjudication rate for any offense was 19.2%, i.e., 28 out of 146 youth were re-adjudicated for any offense.

The re-adjudication rate for another sex offense was 4.1%, i.e., 6 out 146 youth were re-adjudicated for a repeat sex offense.

Maryland Department of Juvenile Services
Qualifications &Training for Clinicians & DJS Staff Who Provide Direct Services to Adolescents Who Offend Sexually

Clinicians

DJS requires clinicians who provide services for youth who sexually offend to meet the following criteria:

- Minimum of a masters degree in psychology, social work or a related field and/or medical degree with a specialization in psychiatry, pediatrics or behavioral medicine awarded by an educational entity that is accredited by a national/regional accrediting board.
- Competence in psychotherapy and assessment as evidenced by a license to practice clinical social work, psychology, marriage and family therapy, professional counseling or medicine.
- Specialized expertise in sex offender treatment as demonstrated by documented training and supervised clinical experience in assessment and treatment of adolescent sex offenders as documented by training and supervised clinical experience. At least 1500 hours of direct clinical experience in sex offender treatment. (Direct clinical experience is defined as face-to-face contact with clients/patients/youth, direct supervision, training, case coordination and/or research. A portion of the qualifying experience must have involved work with juvenile sex offenders.) of the 1500 hours, at least 500 of the hours must have involved the assessment or treatment of juvenile sex offenders. Clinical service providers must attend up to three days of specialized, mandatory training designed and presented by DJS and other professional presenters. This training will be considered as part of the 1500 hour requirement.
- At least 40 hours of formal training annually through documented conferences, seminars, symposia and course work related to evaluation and treatment of sex offenders.

  Such training may include:
  - Internet sex offending;
  - Research on adolescent sex offenders;
  - Youth with sexual behavior problems: Common misconceptions vs. current findings;
  - The language of sex offending: the important words & what they mean;
  - Sexual dysfunction;
  - Etiology and manifestations of psychiatric disorders in children and adolescents;
  - Risk assessment;
  - Adult sex offending;
  - Sexual addiction;
  - Sexual deviancy ;
  - Theories of juvenile delinquency and how the juvenile sexual offender may differ from the general delinquent population;
  - Victimology and victimization issues with an emphasis on child abuse, maltreatment, and domestic violence;

- DJS system and levels of service and care;
- DJS protocols for the assessment and supervision of youth who sexually offender;
- Behavioral/cognitive therapy methods;
- Reconditioning and relapse prevention;
- Child & adolescent physical and psychological development;
- Normal sexual development;
- Individual, group, and family therapies;
- Family and systems theory;
- Ethics and professional standards;
- Psychometric tests;
- Dealing with resistance;
- MST with aggressive youth;
- Psychopharmacology with children and adolescents;
- Role of the family in adolescent sex offender assessment;
- Adult and juvenile psychopathy;
- Working with special population sex offenders (developmentally challenged, female, African American, Latino, etc); and
- Conducting & writing a sex offender assessment.

Licensed professionals and professionals in graduate training and/or post graduate residency who do not meet experience and training requirements may be considered for eligibility to provide clinical services to youth who have sexually offended. Licensed professionals not meeting the experience requirements specified above shall be considered for eligibility to provide clinical services to youth who have sexually offended if the professionals have an arrangement for ongoing supervision with a professional meeting the above criteria. Professionals in graduate training and/or post graduate residency shall be considered eligible if they work as part of a degree program leading to licensure and their clinical work is supervised by a professional meeting the above criteria. [Supervision means one (1) hour of supervision every week by a provider who is pre-approved by the DJS Director of Health Care Services.]

In addition, the provision of treatment services to sex offenders requires that a therapist be comfortable discussing various types of deviant sexual behavior and be able to communicate with clients in a professional, caring empathetic manner. The therapist needs to be aware of his or her own sexual attitudes and beliefs in order to avoid communicating personal bias. The therapist must be comfortable discussing sexual topics with adolescent offenders. The offender's comfort level in discussing the intimate details of an offense is dependent on the comfort level of the clinician who is hearing the disclosure and on the provision of a safe, nonjudgmental forum in which the offender can disclose.

The therapist also needs to be comfortable working with involuntary clients, being appropriately confrontational when necessary, setting limits and boundaries, seeking and enforcing sanctions when necessary, holding the juvenile accountable for behavior and using Court leverage when necessary. These need to be done in the context of caring for the welfare of the adolescent sex offender.

The therapist should be comfortable testifying in Court and writing reports to the Court and CMS. The clinician should be comfortable being part of a multidisciplinary team and interacting with other professionals.

DJS Staff

DJS staff who provide Pre-Disposition Investigations, Probation and Aftercare for youth who have sexually offended must meet the follow criteria:

- At least a Bachelors Degree in Psychology, Sociology, Criminal Justice, Social Work or related field;
- Preferably a Case Management Specialist II with a minimum of two (2) years experience working with juveniles/families; and
- Specialized expertise as demonstrated by documented training. The training curriculum includes but is not limited to:
    - Review of Research on Adolescent Sex Offenders;
    - Community Safety and Supervision Issues;
    - Children with Sexual Behavior Problems: Common Misconceptions vs. Current Findings;
    - The Language of Sex Offending;
    - Overview of Risk Assessments;
    - Maryland Department of Juvenile Services Protocols for Supervising Juvenile Sex Offenders;
    - Child and Adolescent Development;
    - Talking with Children & Adolescents About Sexual Issues: Interviewing and
    - Female Adolescent Sex Offenders.

As with the therapist, the provision of direct services to sex offenders requires that the CMS be comfortable discussing various types of deviant sexual behavior and be able to communicate with clients in a professional, caring manner. The CMS needs to be aware of his or her sexual attitudes and beliefs in order to avoid communicating rigid, stereotypical attitudes toward sexuality. The CMS must be comfortable discussing sexual topics with adolescent offenders. The offender's comfort level in discussing the intimate details of an offense is dependent on the comfort level of the CMS who is hearing the disclosure and on the provision of a safe, nonjudgmental forum in which the offender can disclose.

The CMS needs to be adept at working with involuntary clients, being appropriately confrontational when necessary, setting limits and boundaries, seeking and enforcing sanctions when necessary, holding the juvenile accountable for behavior, and using Court leverage when necessary. These need to be done in the context of caring for the welfare of the adolescent sex offender. The CMS should be comfortable testifying in Court, writing reports to the Court and being part of a multidisciplinary team and interacting with other professionals.

Maryland Department of Juvenile Services
Protocol for the
Assessment of Juvenile Sex Offenders

Introduction

Assessment of adolescent sex offenders is conducted to develop appropriate intervention and supervision plans, to estimate risk of recidivism, and to inform others who are making important case decisions, such as decisions about placement, release, family reunification and so forth.

Assessment of sexually abusive behavior is an ongoing, dynamic process that occurs throughout the youth's involvement with legal and treatment agencies. DJS has three phases of involvement:

Phase 1: Pre-Court (investigative)
Phase 2: Predisposition (dangerousness, risk, placement recommendations)
Phase 3: Post-disposition, release and termination of treatment (community safety, treatment issues, modality, and successful application of treatment tools)

Phase 1: Assessment During Pre-Court Investigation

The forensic assessment during the pre-court investigation is primarily carried out by law enforcement and child protective services. Assessment should begin immediately in the disclosure/investigation process to initiate monitoring of the alleged offender and the safety for the victim. Early assessment can identify risk concerns for youth in community settings (National Task Force on Juvenile Sexual Offending, 1993). However, the pre-court assessment needs to be conducted with care to avoid the pitfall of self incrimination of the youth prior to adjudication (Hunter & Lexier, 1998*).*

In performing the pre-court assessment, the DJS Intake Officer must consider the following and may require referral or consultation with specialists and/or clinicians:

- Seriousness of offense;
- DJS Risk Assessment Inventory (RAI) findings;
- DJS Intake Risk/Needs Screen;
- Presence of anger and/or aggression in commission of the offense;
- Potential suicide risk of the accused;
- Potential retaliation against accused;
- Protection/safety/access to alleged victims and/or other vulnerable persons;
- Family reactions and ability to manage the crisis precipitated by the disclosure; and
- Family's ability to continue to supervise.

Upon review of the case materials, the Intake Officer may decide to:

- Disapprove the case;
- Resolve the case at Intake;
- Forward the case to the State's Attorney; and
- Assign youth to pre-court supervision.

At this time the Intake Officer may refer the youth and/or family to community-based resources, such as local clinics, counseling center or insurance-provided services.

If a sexually abusive youth is taken into custody and is determined by the Intake Officer to be of sufficient risk, the Intake Officer may authorize "overnight" detention or shelter until the next court date. At the arraignment/continued detention or shelter hearing, the court hears the facts in the case to make a decision whether to detain or shelter the youth or continue detention or shelter.

Phase 2: Predisposition Assessment

The ideal time to begin a more in-depth evaluation process is during the development of the predisposition investigation (PDI) reports. The primary purpose of these reports is to provide information about a youth who has sexually offended to the court to assist in the disposition of the case. Critical elements of the case, will determine the level of assessment that a specific youth will require. DJS utilizes a two-tiered assessment system. The first tier is for all youth charged with sexual offenses. The second tier adds a comprehensive sex offender assessment based on the multiple considerations.

A. Predisposition Investigation Report

Per the Protocol for Supervising Juvenile Sex Offenders, a specially trained Case Manager Specialist will prepare an enhanced Predisposition Investigation Report (PDI). The PDIs completed on all youth who have been charged with sexual offenses. The report considers the following elements:

- The police record which details the instant offense;
- The offender's personal history;
- The offender's sexual history;
- Collateral interviews;
- An evaluation of the offender's amenability to specialized treatment;
- Victim access;
- Victim impact statement;
- The level of risk the offender poses to the community as measured by the DJS Classification and Placement Instruments; and
- Corresponding recommendations concerning residential placement or community supervision with special conditions.

In addition, the Case Manager Specialist administers a structured sex offender risk assessment tool, the Juvenile Sex Offender Assessment Protocol –II (J-SOAP II) or the Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0(ERASOR2), and/or a tool to assess the presence of antisocial traits and clinical issues, such as the HARE Psychopathy Checklist. (See description of tools in Section B. below.) The findings from these tools are incorporated into the final report to the Court.

B. Clinical Assessment

A comprehensive psychosexual assessment should be performed by a clinician when serious issues are raised in the Predisposition Investigation Report, and when the following factors: severity of the charge, multiple sex offense charges, injury to victim, incapacitation of victim, previous charges and aggravating circumstances. The comprehensive assessment will form the base for treatment planning, and to guide program placement (Berenson, Underwood, & CJCA Administrators, 2001).

The clinical assessment may require several sessions with the youth and family. The assessment can include a detailed record review, structured clinical interviewing, the administration of psychometric instruments related to personality adjustment and functioning, and the administration of specialized instruments designed to assess sexual attitudes and interests.

Both risk and needs assessments are a part of the overall evaluation. The assessment determines whether the youth can remain in the community or need to be removed and the appropriate levels of supervision, security and monitoring required (National Task Force on Juvenile Sexual Offending, 1993). The risk assessment determines the likelihood that a youth will continue to exhibit sexually abusive behavior and thus be dangerous to others in placement or in the community. The assessor may complete one of the following risk assessment instruments using information garnered from all sources:

- Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II), an actuarial tool, a checklist to promote systematic review of factors "associated with criminal and sexual offending" (Ibid.);
- Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0 (ERASOR2), estimates the "risk of sexual re-offending exclusively among youth ages 12-18 who have previously committed a sexual assault" (Worling, 2001,pg. 3); and
- Protective Factors Scale (PFS), an inventory of variables that help youth to reduce the likelihood of negative behavior.

These assessment tools are being validated and should be used cautiously by trained personnel.

The needs assessment is based on assessments of specific problem areas, strengths and weaknesses, skills and knowledge, and especially of precedents and antecedents of the sexually abusive behavior. Needs assessment should include consideration of "thinking, affect, behavior, organ city, concurrent psychiatric disorders, and family functioning" (National Task Force on Juvenile Sexual Offending). The assessor should identify specifically and in detail the setting, intensity of intervention, and the level of supervision optimal for treatment of the youth.

Clinical Competency

The clinicians who perform these assessments need a thorough knowledge base that must include a "definition of sexual abuse and an understanding of sexually abusive behavior typologies guidelines to assessment and information related to placement

criteria." (Lane, 1997) They must realize that adolescents are a 'moving target', whose development, risk status, and, often, life situation are neither "fixed nor stable" (Prentky & Righthand, 2003). Sex offender assessors must appreciate the duality of the assessment process, i.e., addressing youth and family needs while protecting society from those who represent high risk. (Ibid) Often these youth do not come to the evaluation voluntarily; they "may be embarrassed, defensive, ashamed or self-protective." (Lane, 1997) Likewise, family members may present "minimization, denial, or other protective" features (Berenson and Underwood, 2001). (For further detail, refer to "Qualifications and Training for Clinicians and DJS Staff Who Provide Direct Services to Adolescents Who Offend Sexually" document.)

Assessment Preparation

In order to secure a comprehensive assessment in a timely manner, the DJS Case Management Specialist completes authorizations for the release of information with which to obtain collateral data. Copies of the releases remain in the youth's case file while the originals are mailed. The Case Management Specialist follows up weekly until all materials are received. Copies of the collateral materials become part of the youth case file. The DJS Case Management Specialist who makes the referral for the sex offender evaluation sends the collateral material along with police reports, victim statements and DJS information to the clinician at the time of referral.

Preparation for the assessment must begin with the review of collateral materials including: "police reports; parent, youth ,witness victim statements; victim therapist reports; agency investigation summaries; pre-sentence investigation reports psychological/[psychiatric evaluations; school records; placement and treatment summaries and summaries of agency involvement" (Lane, 1997; Juvenile Court Probation Department Protocols, 1994, Utah NOJOS), DJS intake risk and need screening and assessment and delinquent offense history. Information in these materials will enable the clinician to reality test the youth's and the family's presentations.

Additional information, sometimes unreported, can be gathered from discussions with social services and police investigators collateral interviews with parents, siblings, teachers, prior therapists, clergy and others may provide valuable perspectives on the youth and his behavior (Lane, 1997).

Prior to the interview, the clinician needs to determine his or her approach with the youth. The most effective approaches are interactional, "non-judgmental and respectful (Ibid). An educational approach may enhance the youth's comfort with providing information. Statements such as, 'People usually do some thinking about what they are going to do. When did you start thinking about doing something sexual with [the victim]?' (Ibid). Closed-ended or *why* questions should be avoided. During the interview, the clinician may have to confront discrepancies between the accounts of the youth and the victim. The clinician's questioning should be assertive but not attacking or demeaning (Ibid).

During their initial contact, the youth and family should be informed of the assessment protocol process and the intent to share information obtained and conclusions developed, with the agencies involved as well as themselves (Ibid.). Once the family and youth understand the limits of confidentiality, they are asked to sign an informed consent as well as authorizations for the release of information.

Psychosexual Assessment Components

Predisposition assessments must be comprehensive and should consider the following factors:

1. Developmental-Contextual Assessment

Developing an understanding of how the youth functions as a whole person is crucial to devising a treatment plan that encompasses all pertinent factors, addressing both offense-specific treatment needs and the youth's capacity to live a fulfilling life while managing sexually abusive behaviors. The context of the youth's life in which the sexual abuse occurred affects the clinician's assessment of offense patterns, the type and extent of treatment needs, and the development of initial relapse prevention strategies.

According to Lane, the developmental-contextual assessment of the youth seeks to identify the following elements:

- Stressors and triggers;
- Personal strengths;
- Ability to form and maintain relationships;
- Developmental history, including phobias, speech/language problems and bedwetting;
- Academic history, including cognitive functioning, learning problems and school engagement;
- Social competencies, activities and interests;
- Trauma history;
- Non-deviant sexual history;
- Temperament;
- Self-concept, including self perceptions and ego strength;
- Medical history, including any concurrent medical and/or psychiatric disorders and character pathology;
- Cultural, ethnic and environmental issues;
- Previous treatment history;
- Substance abuse history;
- Depression, grief, and suicide ideation; and
- Quality of youth's expression and management of anger and conflict.

2. Family Assessment

Assessing the youth's family is accomplished by developing and understanding of how family factors influenced the youth's development, the family's potential to be protective

or threatening, and identification of treatment needs. Efforts should be directed toward gaining an understanding of a number of elements that Lane presents as:

- Family roles and structure;
- Quality and style of interaction;
- How various affective reactions are expressed;
- How caretaking, nurturing, authority, and discipline are conveyed;
- The developmental history of the family;
- How the family interacts with the community;
- The quality and style of communication among family members;
- Styles of coping with conflict;
- Family issues and how individual family members address them;
- Apparent strengths and apparent deficits;
- The family environment;
- How responsibilities are allocated; and
- Family beliefs, values and traditions.

In addition the assessor should consider:

- Family work schedules and access to transportation; and
- Nature of family supervision and back up plan for supervision.

3. Assessment of Concurrent Psychiatric Disorders

A number of sexually abusive youth exhibit concurrent diseases or psychiatric disorders that can have an impact on the youth's amenability to treatment, ability to use tools to manage abusive behaviors, interpersonal interactions and self-concept. Some conditions may have had an impact on the youth's actual execution of abusive behaviors. Most common among youth who sexually offend are posttraumatic stress disorder, attention deficit hyperactive disorder, mood disorders, anxiety and depressive disorders. Less frequent are youth who exhibit bipolar features, paraphilias, Tourette's syndrome as well as eating, dissociative or conduct disorders. Screening for suicide risk is vital (Lane, 1997).

4. Assessment of the Abusive Behavior

Assessment of the abusive behavior for which the youth is initially referred provides information about the cognitions, emotions, and behaviors involved in the offense. Comparison between the referring behavior and the other sexually abusive behaviors that the youth reports becomes the basis for identifying patterns, progression of behaviors, and degree of habituation. The intent is to explore in depth everything the youth did, thought, or felt related to the abusive behavior (Ibid.).

Sexual abuse behavior encompasses:

- The various types of behaviors the youth has committed, including animal cruelty, firesetting and aggressive behavior;
- Indications of progression over time;
- Level of aggression;

- Frequency of behaviors;
- Style and type of victim access;
- Preferred victim type;
- Associated arousal patterns;
- Changes in the sexual abuse behaviors or related thinking;
- The youth's intent and motivation;
- The extent of the youth's openness and honesty;
- Internal and external risk factors; and
- Characteristics of the sexually abusive behaviors.

Analysis of the differences and similarities of sexually abusive behaviors, locations of the behavior, victim characteristics, thinking, and associated circumstances will provide an initial understanding of the youth's abusive patterns" (Ibid.,1997). At this age, many youth may not be introspective enough to answer questions concerning abusive behavior during an interview (Bonner, 2003). This is particular true for the topics of arousal patterns and intent and motivation. Indeed, some youth may not have established a pattern of abusive behavior (Ibid.). The assessor should not expect great detail in interviews, but rather look for acknowledgement that the youth understood that he did something wrong. The extent of a youth's openness and honesty can be difficult to judge.

5. Adjunct Testing

Psychometric testing is used as an adjunct with/to other information sources utilized to produce a comprehensive picture of the youth who is sexually reactive or has offended sexually. Which tests are used is determined by findings from, the review of materials and clinical interview. If the youth has a reading disability, questionnaires should be administered orally. Tests of intellectual functioning may or may not be part of the sex offender protocol. The WISC IV or WAIS III may be administered on an as-needed basis.

Various types of tests are used to help the evaluator gather information concerning the youth. The following is a DJS-approved list of adjunct tests:

- Multidimensional Assessment of Sex and Aggression (MASA) – a multidimensional, computerized self report tool now being validated (Nat'l Task Force on Sex Offending, 1993);
- Rorschach Technique – projective test that reveals personality integration;
- Minnesota Multiphasic Personality Inventory- Juvenile (MMPI-A) or MMPI for youth age 18 or older – Both versions offer insight into personality, psychopathology, dishonesty and malingering (Ibid.);
- HARE Psychopathy Checklist- Youth Version (PCL-YV) – a rating scale that assesses whether antisocial traits and clinical issues are present
  or HARE Psychopathy Checklist Adolescent – a rating scale for youth age 16 and older that assesses antisocial personality disorders;
- Thematic Apperception Test (TAT) –a projective test designed to assess personality;

- Trauma Symptom Check List for Young Children (TSCC) a caretaker report tool or Trauma Symptom Inventory (TSI) – self report tool. The version used is determined by the age of the youth. Both yield a history of trauma including a history of abuse;
- Reynolds Adolescent Depression Scale -2 (RADS-2) – a 30 item, 4 point scale that screens for serious depression;
- Online Sexual Addiction Questionnaire – 24 item questionnaire to assess whether client has a problem with online sexual behavior;
- Bender Gestalt – a paper and pencil activity that tests perceptual-motor and cognitive development and can indicate organicity;
- Hand Test- an ancillary technique using pictures of hands in ambiguous poses that reflect higher order behavioral tendencies that may be classified into psychologically meaningful categories;
- House-Tree-Person – a drawing test that reveals organicity and personality;
- Child Sexual Behavior Checklist (CSBC)- this 4-part assessment is designed for use with youth age 12 or younger; and
- Abel Assessment for Interest in Paraphilias (Ibid.) computerized assessment of sexual interest based on responses to viewing slides.

A neuropsychological test and/or psycho-educational test is/are utilized if the tester is concerned about learning disabilities and/or neurologically based deficits (American Academy of Child & Adolescent Psychiatry, 1999).

Upon occasion the Department permits use of other psychometric tests so long as they are accepted as valid tools by the sex offender treatment community.

Analysis of Information

The information gathered during the assessment process is used to develop a comprehensive treatment plan that addresses all identified needs of the youth and considers community safety. The recommendations consider offense-specific treatment and family, psychological and psychiatric, developmental and safety needs. The concern is to provide safety and treat the youth in a way that preserves the family, if appropriate, and provides a treatment structure from which the youth can benefit. The goal is for the youth to develop sufficiently healthy, adaptive, pro-social functioning so that he can internally manage life's stresses and avoid sexually abusive behaviors.

The Sex Offender Assessment Report

The format of the of the sex offender assessment should be uniform throughout DJS. This report is intended to inform Case Manager Specialist Specialists, court personnel, legal representatives and service providers. Jargon should be avoided. Professional language may be used with definitions appropriate to a lay audience. The presentation of findings from the assessment interviews and review of materials should be consistent with the final recommendations. The report should conclude with clear recommendations for level of supervision and specific treatment needs. The assessor should contact Case Manager Specialist about questions of resource availability, etc.

Sections of the Report include the following:

- Identifying data: name, age, gender of youth and description of instant offense.
- Records reviewed: a listing of all items reviewed by date, institution, author & descriptive note of content.
- Assessment tools employed: a listing of all evaluative procedures should be provided with an explanation of any that may be unfamiliar.
- Interviews conducted: a listing of all persons interviewed and whether telephone or face-to-face.
- Referral question & circumstances.
- Clinical Observations.
- Historical Information:
    - Developmental and health history.
    - Family history.
    - Academic history.
    - Substance abuse and delinquent history.
    - Treatment history.
    - Psychosexual History.
        - Normal psychosexual markers.
        - Problem areas, especially episodes of client being sexually abused or a sexual predator.
- Assessment Findings: cognitive functioning, personality symptomatology, sexual attitudes, formulation, summary.
- Diagnoses/Prognosis.
- Recommendations: As Lane (1997) and others note, multiple factors should be considered:
    - Community Safety Needs
        - Protection for potential and known victims.
        - Intensity and nature of supervision.
        - Identification of risk potential.
        - Identification of the treatment setting, intensity and type.
        - Limitation of access to potential opportunities.
        - Provision of supervision conditions that will reduce likelihood of re-offense.
    - Offense-Specific Treatment
        - Identification of needs relevant to the sexually abusive behavior.
        - Identification of risk factors and safety plans.
        - Assessment of treatment amenability.
        - Service and placement considerations.
    - Mental Health, Substance Abuse and Education Needs
        - Identification of adjunct treatment and concurrent disorders.
        - Indication whether adjunct services need to occur prior to offense-specific treatment or concurrently.

- Family Needs
    - Identification of family's educational and intervention needs.
    - Identification of specific treatment needs for any identified dysfunction or deficit.

Phase 3: Post-disposition, Release and Termination of Treatment

Phase 3 encompasses the timeframe from the court disposition through termination of treatment in two tiers. Tier One includes post-disposition and provision of services; Tier Two involves release and termination from treatment. Throughout these stages, the Case Manager Specialist works with the family, youth and clinicians and other service providers to revise the treatment and the community safety plans. Every ninety days the youth's treatment plan will be revised and reviewed by the Case Manager Specialist Supervisor. The Case Manager Specialist is expected to adhere to the Department's policies concerning probation and aftercare. (Refer to Protocols for Supervising Juvenile Sex Offenders for specific instruction for working with these youth.)

A. Post-disposition

Post-disposition includes the court's disposition on the case, the development and revision of the treatment plan, selection of treatment modality, successful engagement of the youth and family in treatment and monitoring of community safety. Request for reassessment of the youth may be based on one or more factors: additional charges, sexual offense disclosures, new information and/or failure of treatment.

B. Release and Termination of Treatment

Release and Termination of Treatment includes the aftercare plan and transition of youth to community or lower level of service. The Case Manager Specialist should require a discharge plan from the service provider. This is especially important if the youth is returning from a residential program. At times an independent assessment may still be needed to assist the Case Manager Specialist to develop the aftercare plan.

The aftercare plan should incorporate the recommendations from the discharge plan from the service provider as well as recommendations from any prior assessments. The aftercare plan should address:

- community safety needs, including victim access;
- continuing offense-specific treatment needs;
- continuing services for mental health, substance abuse or education/vocation; and
- family needs, including family responsibilities and protocols if the victim resides in the home.

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Maryland Department of Juvenile Services
Protocols for Supervising Juvenile Sex Offenders

Background

Although available research does not suggest that the majority of sexually abusive youth are destined to become adult sex offenders, legal and mental health intervention can have significant impacts on deterring further sexual offending. Currently, the most effective intervention consists of a combination of legal sanctions and specialized clinical programming. It should be noted that in spite of limited research on effective treatment for juvenile sex offenders, empirically based approaches designed specifically for delinquent populations should be used in the treatment of this population.

The prevailing view until recently has been that early clinical intervention is needed to break the cycle of sexual deviance, and that intervention should take the form of lengthy, offense-specific, peer-group therapy although there is no evidence to support this view. Researchers who have reviewed studies and conducted comparative analyses report that it is not possible to say whether one type of treatment is better than another, with the possible exception of delinquency focused multisystemic treatment, which appears to be more effective than individual counseling with juveniles who have committed sex offenses. There is no evidence to support a “heavy handed” correctional or justice response in treating juvenile sex offenders.

Many jurisdictions around the nation have embraced the concept that supervising sex offenders in the community effectively requires a highly specialized approach to community supervision. Although there are individual variations in each community, the most promising approaches share several key elements, including:

- thorough pre-sentence investigation reports (PDI);
- complete offender assessments;
- the use of empirically validated risk tools where possible;
- the establishment of case management teams;
- highly trained and specialized case managers;
- the use of sex offender specific conditions of supervision;
- mandated sex offender specific treatment;
- the use of the polygraph in selected cases as deemed necessary; and
- individualized treatment service plans.

Such approaches also focus primarily on the safety and needs of victims and the community and require that a wide array of individuals and agencies work together to solve the problem of preventing further victimization.

Supervision

Some research indicates that standard supervision of youthful sex offenders is effective with some modification to increase public safety. To date, no studies have been conducted that clearly identify which supervision strategies are most effective with these youth. Key components are: interagency collaboration, multidisciplinary teams, the specialization of supervision and treatment staff; and program monitoring and

evaluation, which ensure prescribed policies and practices are delivered as planned (English et al, 1996). Generally, different supervision and treatment approaches are needed for children ages 8-12 than for adolescents. Younger children can be treated without adjudication unless it is necessary to insure treatment. There are program models for treatment of non-adjudicated juvenile sex offenders which emphasize the responsibility of the parent or primary care giver to be involved with treatment.

The Role of DJS Community Case Manager Specialists

DJS Community Case Manager Specialists play an integral role in assisting treatment providers by addressing critical issues and supervising youths' activities in the home and community. DJS Community Case Manager Specialists help evaluate the extent to which clients are productively participating in the treatment program and complying with court and therapeutic directives. They provide an additional link between the provider and youths' families, and often assist therapists in impressing upon families the importance of their involvement in the youths' rehabilitative programming. In some instances, DJS Community Case Manager Specialists participate directly in the delivery of therapeutic services as co-therapists in treatment groups. While there is little consensus among the treatment community about the proper role of DJS Community Case Manager Specialists in the treatment of young sexual abusers, at a minimum, the role must include communication and collaboration with treatment providers.

Typically, DJS Community Case Manager Specialists provide an essential case management function. This includes analysis (sometimes with the help of social services) of the appropriateness of youth receiving in-home treatment and of the need for supplemental community programming, such as community service projects. As Specialists, DJS Community Case Manager Specialists also facilitate appropriate communications between treatment providers and other community agencies, such as school officials involved in the youths' overall care.

Assessment of the Youth's Home

Assessments of the juvenile's appropriateness for community-based programming should include a thorough review of his or her living arrangements, as well as a determination as to whether his or her parents are capable of supervising the youth. Proper assessment requires evaluation of whether the living environment affords the level of structure and supervision necessary for the youth while providing for the safety of others in the home and the community. Special consideration must be given to the needs and concerns of those living in the home who may have been victimized by the youth (e.g., younger siblings). It is essential that other children are protected from potential harm, both physical and psychological. It is often necessary to place a juvenile who sexually offends against family members temporarily outside of the home. These youth should not be returned home until sufficient clinical progress is attained, and issues of safety and psychological comfort of family members are resolved. For an adjudicated youth, this decision is typically made by the Juvenile Court with input from

the DJS Community Case Manager Specialist and social services worker, the youth's treatment provider, the provider of services to family victim(s), and the youth's family.

The Pre-Disposition Investigation

An examination of the needs and risks of sex offenders and a careful review of the capacity of the existing management system to supervise this population effectively is a vital function of DJS. The DJS Intake Process includes review of the police report; victim impact statement, if available; an interview with the youth and family and objective risk and needs assessments. Standard operating procedures are followed at Intake in compliance with state laws and regulations mandating the forwarding of certain offenses for formal court involvement. Less serious offenses can be handled through informal supervision and linkage with assessment and treatment resources within the community, specifically for families who seek assistance and are involved in the youth's treatment. Those cases requiring formal court involvement are forwarded to the States Attorney for filing of a delinquency petition and eventual adjudication (finding that the offense has occurred). The ideal time to begin a more in-depth evaluation process is during the development of pre-disposition investigation (PDI) reports. The primary purpose of these reports is to provide information about a sex offender to the court to assist in the disposition of the case. The PDI presents an opportunity for a DJS Community Case Manager Specialist to make a recommendation for or against community supervision; assess amenability to treatment; and to recommend specialized conditions of supervision based on the offender's delinquent/criminal and sexual history and their risk to re-offend.

Critical Elements of Pre-Disposition Investigation Reports

Ideally, PDI reports should be generated by specialized DJS Community Case Manager Specialists who have an extensive working knowledge of sex offenders and their patterns of behavior. In addition to standard components of the PDI, these reports should include:

***The police record which details the instant offense*:** PDI writers should review thoroughly all charging documents that provide details about the crime. Whenever possible and if applicable, writers should also attempt to gain access to any police records detailing prior allegations of sexual abuse.

***The offender's personal history*:** Obtaining the sex offender's family and personal history should occur during the initial interview with the youth and family. Information gathered should include family situation, the ages and genders of offender's siblings, school and employment history, financial history, medical background, previous treatment and substance abuse history. Securing this type of information allows the DJS Community Case Manager Specialist to discuss areas that are typically non-threatening to the offender and provides an opportunity to establish rapport before broaching the sexual aspects of the report. Other areas that should be explored in greater depth when interviewing a sex offender include the offender's relationship history and past physical and sexual abuse the offender has experienced.

***The offender's sexual history*:** It is critical for DJS Community Case Manager Specialists to ask probing questions about a youth's sexual history. Interviewers should ask only open-ended questions with positive assumptions, as this technique may evoke

responses that provide the detailed information that is needed to assess accurately the offender's patterns of sexually abusive behavior. For example, interviewers should ask: "When did you begin touching your sister inappropriately?" Rather than "Did you ever touch your sister inappropriately?" Note: Specially trained DJS Community Case Manager Specialists with specialized caseloads may ask these kinds of questions; however in jurisdictions where workload does not allow for specialization, these questions may be best posed by the clinical evaluator.

***Sex offender specific evaluations*:** These evaluations, conducted by psychologists or other trained clinicians, often contain an evaluation of mental disorders, a history of drug and alcohol use, the results of a medical screening, a comprehensive sexual evaluation (including a sexual history), and an evaluation of the offender's levels of denial.

***Collateral interviews*:** DJS Community Case Manager Specialists should also interview the offender's family members, contact school personnel (following departmental confidentiality requirements and using information such as report cards to see which classes the youth attends) and other involved agencies, gather information from prior treatment/evaluation providers, and any other individuals (alternate caretakers) with whom the offender interacts or has interacted with on a regular basis. These individuals can often provide important information about the offender that otherwise would not be known.

***An evaluation of the offender's amenability to specialized treatment*:** In jurisdictions where sex offender specific evaluations are not conducted and the DJS Community Case Manager Specialist must make a preliminary determination about the offender's amenability to treatment, supervising officers should seek answers to the following kinds of questions: Does the offender admit to the offense and accept responsibility for his actions? Does the offender identify his sex offending behavior and express a desire to change? Since sex offenders rarely take total responsibility for their actions at the time of the pre-sentence report, the DJS Community Case Manager Specialist will be attempting to evaluate where offenders are in the process of accepting responsibility and their willingness to participate in specialized treatment.

***Victim access*:** The offender's access and threat to potential victims is perhaps the most critical factor to consider when recommending for or against community supervision. (It is not uncommon for child abusers to be prohibited from having any unsupervised contact with children of any age at the beginning of their community supervision term, for example. Consideration should be given to this issue with offenders convicted of other sexual offenses.)

***A victim impact statement*:** All jurisdictions should encourage the inclusion of a victim impact statement in the PDI, if the victim wants to provide such a statement. This statement should reflect the effects (e.g., emotional, financial, or physical) that the assault has had on the victim's life. DJS Community Case Manager Specialists should work with a victim advocate whenever possible to obtain information from a victim. If this is not possible, PDI writers must take care not to challenge the validity of victims' statements, as most victims have already been interviewed about the details of their assault several times prior to the PDI report. *NOTE: Develop FORMAT; each Area Director shall be responsible for insuring that a process is in place for obtaining victim statements when available. Sensitivity to victim's wishes may be honored by going*

through the local jurisdiction's Child Advocacy Network, victim's case manager or treatment provider.

***The level of risk that the offender poses to the community*:** The PDI's summary recommendation regarding a sex offender's level of risk to the community should be based upon all of the information that the DJS Community Case Manager Specialist has gathered and analyzed during the course of the investigation.

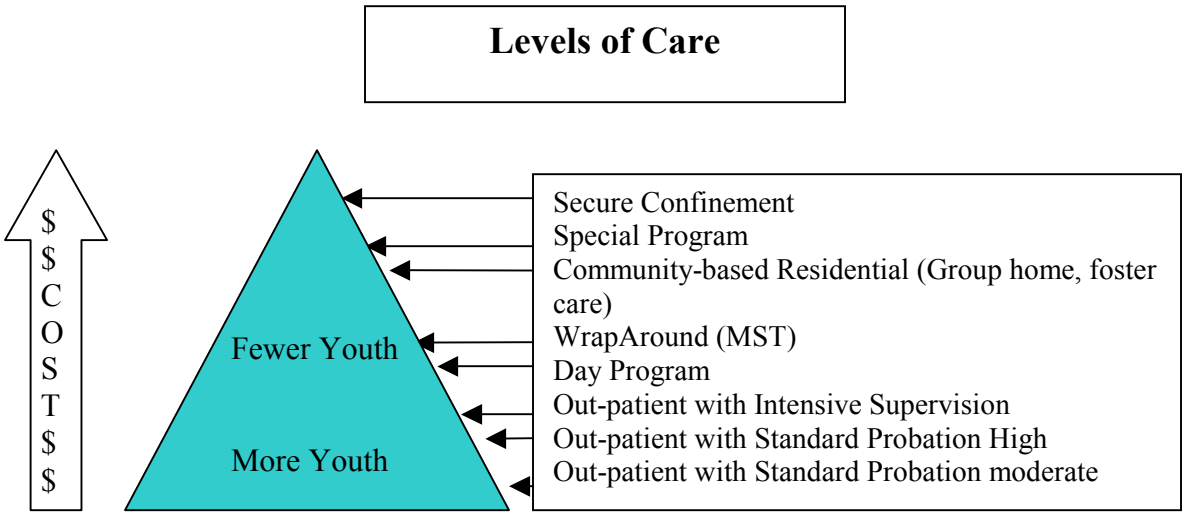
***Corresponding recommendations regarding residential placement or community supervision with special conditions*:** The recommendation section of the report should refer to recommendations regarding risk that were identified during the sex offender specific evaluation; resources that are available which support the juvenile justice system management of the offender's risk in the community (e.g., supportive family, specialized treatment, sufficient supervision resources, and ability to limit access to victims); a list of special conditions needed to monitor risk if probation is recommended; DJS Community Case Manager Specialists must recommend conditions of probation that specifically address the offender's sexually abusive behaviors.

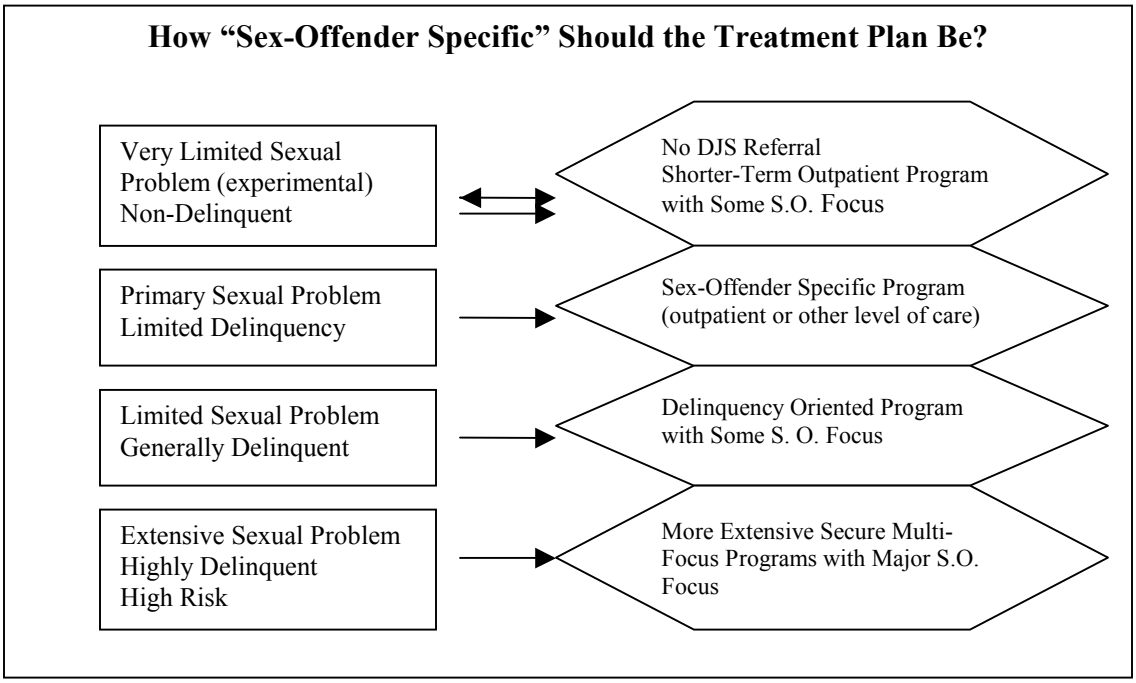
The PDI, therefore, should inform the disposition decision and help set the framework for community supervision, when community supervision is deemed appropriate.

Sex Offender Classification

Classification for risk and need should be based upon the results of empirically-based instruments that have been statistically validated. Tools should be valid in distinguishing varying levels of risk and need among the offenders in a specific jurisdiction. Empirically-based instruments that have been statistically validated provide jurisdictions with reasonable and reliable sex offense risk prediction.

Currently the Risk Assessment for Adjudicated Youth is used to guide supervision and placement levels for all adjudicated youth. This risk assessment should be used in conjunction with a specialized assessment tool (research-based predictive questions addressing sex offender risk for re-offending). The tool should be completed by specially trained DJS Community Case Manager Specialists who make these classification decisions. The Sex Offender Task Force recommends that DJS Community Case Manager Specialists use the HARE Psychopathy Checklist Adolescent and the Child Sexual Behavior Checklist (for those under twelve years of age). These specialized assessment tools may be more appropriate for use by the Community Case Manager Specialist than the ERASOR or J-SOAP-II which are better utilized with a comprehensive clinical interview and psychological testing indicating the presence of mental health issues.


Levels of Care
$ $ C O S T $ $
Fewer Youth
More Youth
Secure Confinement
Special Program
Community-based Residential (Group home, foster care)
WrapAround (MST)
Day Program
Out-patient with Intensive Supervision
Out-patient with Standard Probation High
Out-patient with Standard Probation moderate


How "Sex-Offender Specific" Should the Treatment Plan Be?
Very Limited Sexual Problem (experimental) Non-Delinquent
No DJS Referral
Shorter-Term Outpatient Program with Some S.O. Focus
Primary Sexual Problem Limited Delinquency
Sex-Offender Specific Program (outpatient or other level of care)
Limited Sexual Problem Generally Delinquent
Delinquency Oriented Program with Some S. O. Focus
Extensive Sexual Problem Highly Delinquent High Risk
More Extensive Secure Multi-Focus Programs with Major S.O. Focus

Development and Maintenance of the Treatment Service Plan

The treatment service planning reflects all the available and relevant information regarding the offender, including the special conditions of probation or aftercare. During the supervision period, the treatment service plan will reflect information that either supports the direction of the initial treatment service plan or requires the use of a different approach or strategy. The treatment service plan is meant to be a useful document, updated when changes occur and created in a format that any staff person involved in the youth's supervision can use.

Treatment service plans that guide the supervision of sex offenders are a key component of a comprehensive approach to sex offender supervision. Treatment service plans should explain the sex offender's responsibilities while under community supervision and eliminate confusion regarding the expectations that DJS Community Case Manager Specialists, treatment providers, and other stakeholders have developed for the offender. Review of Treatment Service Plans occurs every 90 days or when new charges occur. Risk re-assessments occur simultaneously with Treatment Plan review through the use of empirically-based instruments that have been statistically validated.

The development and maintenance of a comprehensive and up-to-date treatment service plan is a multi-faceted process that requires input and feedback from the offender, the DJS Community Case Manager Specialist, and other professionals who share responsibility for sex offender management. In sex offense cases, it is extremely important to involve the offender and family in the treatment service planning process in order to ensure that all parties are aware of, and accept responsibility for, the terms of supervision and that any changes or adjustments to the treatment service plan are discussed. DJS policy already requires that the juvenile and parent/guardian sign and date the document, thereby indicating acknowledgement of having reviewed and understood it, and indicate willingness and commitment to abide by the conditions outlined in the plan.

The standard DJS Treatment Service Plan includes some of the recommended components and is expanded (Addendum for Sex Offenders?) to meet recommended standards:

- biographical data (e.g., name, date of birth, address, and/or employment);
- the type of sex offense;
- the level of risk;
- risk factors with an emphasis on dynamic—or changeable—risk factors and acute dynamic factors (e.g., those that suggest imminent danger to re-offend, such as intoxication);
- special conditions of supervision; and
- how and when the offender is to fulfill specific responsibilities (e.g., completion of community service work and payment of fines or court costs); and information regarding the role of the supervision agency and how supervision will be structured (e.g., with the use of electronic monitoring, drug/alcohol testing, curfews, and other restrictions on movement).

All aspects of the treatment service plan must be updated as changes occur in the offender's behavior, and as his compliance with his supervision conditions improves or deteriorates. Using relevant documents (e.g., treatment progress or school reports), information that is gleaned from home visits or office visits in the community, and feedback received from collaterals, DJS Community Case Manager Specialists should continually monitor the youth's compliance with supervision conditions and the risks his environment may present. Treatment service plans should consider whether the current supervision conditions adequately address the offender's risks and needs or allow the offender access to past or potential victims.

In the event of staff reassignment, a new DJS Community Case Manager Specialist should be able to use the treatment service plan to understand an offender's needs, issues, and current supervision conditions. It is vital for DJS Community Case Manager Specialists to maintain clear chronological case notes that detail an offender's progress-or lack thereof-in supervision and treatment. Current and complete information also fosters communication among other members of the supervision team and can serve as a foundation for the formal and informal case management discussions.

When residential placement is determined to be the appropriate level of treatment, aftercare supervision begins upon admission, the residential program receives the initial treatment service plan, the Community Case Manager Specialist offers input into the residential program's plan for the youth and, as re-entry to the community approaches, the Community Case Manager Specialist begins to develop the aftercare release plan. The DJS Aftercare Policy and Intensive Aftercare Policy address required actions and responsibilities for youth in placement and youth transitioned to the community from placement. These policies are consistent with the description of treatment plan development and maintenance and supervision requirements described in the following paragraphs.

Key Elements of Community Supervision

Standard community supervision practices (e.g., scheduled office visits, periodic phone contact, and community service requirements) may adequately address the unique challenges and risks that sex offenders pose to the community if they are enhanced to address treatment and public safety concerns. The DJS Community Case Manager Specialist should assess an offender's place of residence and employment, restrict contact with minors or other potential victims, coordinate appropriate treatment for the youth and family, and establish, if necessary, other restrictions that diminish the likelihood of re-offense.

Sex offenders must be monitored intensively during community supervision in order to evaluate their level of commitment to and compliance with all imposed special conditions. This supervision typically should include:

- ensuring that the offender is actively engaged in and consistently attending an approved community-based treatment program;

- verifying the suitability of the offender's residence, educational placement and place of employment;
- monitoring the offender's activities by conducting frequent, unannounced field visits at the offender's home, at school, at his place of employment, and depending on level of risk, during his leisure time;
- helping the offender to develop a community support system—including family members, school support staff and employers who are supportive of the community supervision plan, and, subject to confidentiality mandates, can recognize the sex offender's risk factors; and
- maintaining regular contact with the offender's family, treatment provider, and other community members through a wraparound approach.

Empowerment of family, use of non-traditional resources and extensive contact also can provide an opportunity for community members to express concerns they may have about an offender's behavior.

Special Conditions

Special conditions of supervision are used to add restrictions to the general terms and conditions of supervision. Although many traditional methods of supervision (such as field visits, collateral contacts, surveillance, drug and alcohol testing, and electronic monitoring) are appropriate to utilize when supervising sex offenders, probation and aftercare conditions should also address their sex offense histories and individual patterns of offending. Sex offender specific conditions have emerged as one of the key tools in managing this particular population of offenders.
Examples of offense-specific conditions which address directly the offender's cycle of abuse: no watching television programs or videos that act as a stimulus for their abusive cycle, or act as a stimulus to arouse them in an abusive fashion; not to be unsupervised where children congregate, such as parks, playgrounds, and schools.

While special conditions provide a foundation for the development of a comprehensive case management plan, probation and parole officers should tailor the specific supervision conditions in each sex offender's treatment service plan to address individual risks and needs. Specialized conditions for the supervision of sex offenders usually address:

***Disclosure*:** Signature on a waiver allowing shared communication among treatment provider, DJS, and the court; and disclosure to others as appropriate.
***Treatment*:** Participation in and payment for evaluation and approved sex offender specific treatment covered by a signed contract.
***Victim Contact and Restitution*:** Only approved, supervised contact with the victim(s) or their families (including contact through third parties) and payment for victims' counseling. (Victims are sometimes family members. As a team, the treatment provider and DJS Community Case Manager Specialist determine when contact is appropriate based on the offender's and family's response to treatment. It is advised that visits progress from supervised phone calls to day and then overnight visits to family.)

***Restricted Contact with Children*:** Only supervised, approved contact with younger children.
***Daily Living*:** Residence only in the supervising jurisdiction; no unapproved visits with family; and maintenance of established curfew hours.
***Social/Sexual Behavior*:** Full appropriate dress when public view is possible; may not spend time in locations where younger children are likely to be; no non-therapeutic contact with adjudicated or convicted sex offenders; and no view, purchase, or possession of adult-oriented materials.
Work (paid or volunteer): No such activity where contact with younger children is likely.
***Alcohol/Drugs*:** No purchase, possession, or consumption; testing as requested.
***Polygraph and Other Tests*:** Only in certain cases when deemed necessary and only by experienced, qualified testers.
***Computer/Internet Restrictions*:** Offenders must not use the Internet without permission of their DJS Community Case Manager Specialist and must submit to an examination and search of their computer to verify that it is not utilized in violation of their supervision and/or treatment conditions.
***Other Technology Restrictions*:** It is possible that certain offenders should not possess a camera, camcorder, or videocassette recorder/player without the approval of their DJS Community Case Manager Specialist. Parents must block access to "900" numbers.
***Other Employment Restrictions*:** Offenders cannot hold a position that allows them to supervise children.

Developing a supervision strategy to protect potential victims may also involve random home checks after curfew; restriction of the youth's access to vehicles; frequent contact with the family, school officials, and employer; and the administration of unscheduled polygraph examinations.

Special supervision conditions, when ordered by the court or the DJS Community Case Manager Specialist, are perhaps the most effective method of imposing external controls on sex offenders. In order to reduce the likelihood of a sexual re-offense, these restrictions must be designed to address the offender's risk factors, and DJS Community Case Manager Specialists must consistently monitor the offender's adherence to all of the conditions of probation. DJS Community Case Manager Specialists should continually assess whether the conditions assigned to sex offenders appropriately address their current patterns of behavior (including social interactions) and living conditions. For example, a DJS Community Case Manager Specialist may discover during a conversation with a family member that a younger relative is spending time in the offender's household and may impose an additional condition that forbids the offender from being in the home alone with the child. This ongoing and intensive evaluation of an offender's behavior will also reinforce his awareness of supervision.

Specialized vs. non-specialized Caseloads

The results of nationwide survey of sex offender supervision practices in the adult system nationwide indicate the following benefits which can be applied to caseload specialization within DJS:

- DJS Community Case Manager Specialists gain expertise and training related to sex offender management;
- DJS ensures that sex offenders, who might have become "lost" on non-specialized caseloads because of their seemingly compliant nature, are supervised intensively;
- DJS Community Case Manager Specialists establish rapport with sex offenders in order to encourage them to talk openly about their thoughts and activities;
- Promotes feelings of camaraderie and support among counselors who maintain these caseloads in order to reduce secondary trauma; and
- Increases agency-wide consistency in sex offender supervision practices.

Specialized counselors should have extensive supervision experience; be trained in sex offender issues such as treatment and assessment; be knowledgeable about child and adolescent development; be knowledgeable about victimization; and have interest in and a commitment to working with this population.
Specialized counselors play a different role in supervising sex offenders than other DJS Community Specialists who are responsible for non-specialized caseloads. They must be more involved in the offender's daily life and habits and be in contact with others knowledgeable about the offender's current attitudes and behaviors. Sex offender supervision counselors have found that the following practices enhance their ability to monitor an offender's behavior and state of mind:

- open discussions with the juvenile offender regarding his progress in identifying and avoiding pre-offense planning and behaviors and his understanding and use of relapse prevention strategies;
- detailed discussions of any contact the offender may have had with past or potential victims followed by verification of that information with the offender's family or others in his support network;
- close monitoring of the offender's school progress and employment; and
- recognition of treatment progress and other positive achievements.

Relating these finding to the juvenile justice system, specialized supervision of sex offenders requires a DJS Community Case Manager Specialist to be able to talk openly about sexuality and sexual deviancy; to be knowledgeable about offender, victim and family issues; and to work collaboratively with treatment providers and other stakeholders to ensure compliance with community supervision and treatment requirements.
As noted in references to the adult system, mixed probation/aftercare caseloads in the juvenile justice system can also be an effective way to manage sex offenders, as long as sex offenders are assigned only to DJS Community Case Manager Specialists who receive ongoing, specialized training and caseload size is minimized.

Minimum Standards of Supervision

Throughout the course of the offender's supervision, DJS Community Case Manager Specialists must, at a minimum, be able to:

- check an offender's residence, school and place of employment;
- maintain contact with the offender's therapist, family members and other community members, including victims' advocates or Case Manager Specialists and victims when appropriate;
- continue to monitor the youth and family's adherence to the conditions of supervision, including attending school and/or employed and maintaining compliance with rules at home.

The level of supervision should never be so low as to exclude routine field visits to monitor an offender's behavior in the community.

Other considerations

Engaging Others to Assist in the Supervision of Sex Offenders in the Community

Another method that has proven to be especially promising in managing sex offenders is the use of a case management team, or groups of individuals who can augment the management provided by a supervision officer. The use of the case management team (e. g., Intensive Aftercare Team) allows for routine communication among staff who become familiar with the offender's day-to-day activities and can verify compliance with program standards and regulations. Use of community detention can be considered at appropriate phases, such as upon release form residential treatment and transition home or as a sanction for curfew violation.

Enhancing supervision for juvenile offenders can include the wraparound approach of including the family and youth as part of the team and using non-traditional community resources which add protective factors and minimize risk factors for the youth. Carefully selected mentors and advocates (such as those provided by Choice, an advocacy program operated through University of Maryland or those assigned through Psychiatric Rehabilitation Programs) can serve as support to assigned offenders as they attempt to reintegrate themselves into the community, and provide DJS Community Case Manager Specialists with input about the youth's daily life and progress. A positive support system has been found to be an important factor in reducing recidivism in other jurisdictions. Depending on the age, individual treatment needs and level of risk to public safety presented by the youth, the youth's and family's plan can be customized to have varied levels of intensity in community monitoring and reporting requirements. Open information sharing and consultation among the various agencies charged with the management of sex offenders, proactive and intensive community monitoring, and ongoing, offense-specific treatment taking into consideration the youth's age, developmental level, risk to public safety and level of family support/involvement, can equip youth with the necessary skills to refrain from further sexual offending and further delinquent behavior in general.

The Polygraph

The polygraph, a technology that is reported by some to be effective in detecting deception, is being used increasingly as a mechanism to assist in managing adult sex offenders. Current research, however, indicates that there is no scientific evidence that the polygraph is valuable as a deterrent or as way to elicit admissions. In certain rare instances, a qualified and experienced polygrapher may be used as part of treatment.

Drug and Alcohol Testing, and Electronic Monitoring

DJS already uses drug/alcohol testing and/or electronic monitoring for reducing chemical abuse and providing information about offenders' whereabouts as tools of comprehensive treatment service plans. These tools should be used on an individualized basis in a manner that addresses specific sex offender risk factors. For example, it may not be the best use of limited resources to electronically monitor an offender who is surrounded and supervised closely by a group of supportive adults (e.g., an employer, a mother and father, neighbors, or other relatives). In such instances, the resources associated with using these technologies should be applied to offenders who have past histories of substance abuse or have not shown the ability or willingness to abide by court-imposed curfews and other restrictions on movement.

Family Reunification

Family reunification, the process by which an adjudicated sex offender is allowed to return to live in his home with his victims or alleged victims, is an especially controversial issue. The offender who has molested younger children should be initially separated from all children and is required to engage in ongoing and specialized sex offender treatment before any efforts to reunify the offender with his family are initiated.

Family reunification policies also should require that family members be aware of the offender's sexually abusive behavior, participate as needed in the offender's supervision and treatment, recognize the impact that the abuse has had on the victim, and ensure that they are unequivocally willing to monitor the safety and well-being of the victim. DJS Community Case Manager Specialists are essential to the family reunification process in supporting what the treatment provider recommends while at the same time being trained to ask the right questions which require accountability from those family therapists who want to reunify prematurely. Teamwork and guidelines for the offender's return home should be a part of sex offender supervision.

Since the offender is generally a person who is a sibling, family member, or friend of the victim, some victims and families may not oppose reunification. This can happen for many reasons, including that the victim may care for the offender, or fear alienating a parent or other family member by objecting to reunification. Reunification should be a gradual process that is planned and monitored carefully-by community supervision staff, treatment providers, victim advocates and therapists, and the families of the offenders and victims-in order to avoid further traumatization of the victim and other family members.

Sex Offenders with Developmental Disabilities

Many jurisdictions around the country struggle with the issue of supervising sex offenders with developmental disabilities. In Maryland, current Probation and Aftercare caseloads include youth who have been adjudicated delinquent for sex offenses, identified as needing treatment to address offending behavior and have also been identified as having mental health issues (bi-polar, ADHD, Asberger's Syndrome), borderline retardation, receptive language learning disabilities and other identified factors which pose many challenges and require individualized treatment approaches Supervising this population requires:

- evaluating the offender's level of cognitive impairment in order to gauge his suitability for community supervision;
- contracting with treatment providers who are well versed in sex offending behavior and developmentally disabled individuals; and
- working intensively with departments of mental health, social services, group home staff, and others that may be involved closely in the offender's daily life.

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This protocol was developed using as frame work the CSOM **Community Supervision of the Sex Offender: An Overview of Current and Promising Practices January 2000** authored by Leilah Gilligan and Tom Talbot, Program Associates, Center for Sex Offender Management. Edited by Madeline M. Carter, Project Director, Center for Sex Offender Management. Contributions by Georgia Cumming.

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Documents referenced in the CSOM Community Supervision of the Sex Offender: An Overview of Current and Promising Practices January 2000 are listed in the attached "Selected Reading" list.

Selected Reading

Cumming, G., and Buell, M. (1997). *Supervision of the Sex Offender.* Safer Society Press, Brandon, VT.

This publication refers exclusively to adult male sex offenders. Juvenile and female sex offenders pose somewhat different management challenges. For more information regarding juvenile sex offenders, see: Center for Sex Offender Management (1999). *Understanding Juvenile Sex Offenders: Emerging Research, Treatment Approaches and Management Practices.* Silver Spring, MD.

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Maryland Department of Juvenile Services
Treatment of Juvenile Sex Offenders

The Department has created this document to set forth its philosophy and expectations for the provision of treatment services so it can provide quality specialized sex offender treatment for adolescent offenders in accord with best practices. While the Department recognizes that a seamless continuum of services is necessary to address the severity of offending committed by juvenile sex offenders, this document addresses only the provision of services for those adjudicated youth who have been assessed as needing the level of care provided in a specialized community-based juvenile sex-offender treatment program and not requiring the more intense setting of a Residential Treatment Center (RTC).

Review of the Literature

For many years the traditional approach to the treatment of most adolescent sex offenders has been a cognitive-behavioral based group approach that focuses on the establishment of each offender's unique sexual abuse cycle and the development of a relapse prevention plan. Recently, Hunter and his colleagues (2004) have pointed out that this approach has been based on several questionable and, as yet, empirically unfounded assumptions. These include "the assumptions that the general dynamics of sex offending, and therefore the treatment needs, of most juvenile sexual offenders are the same; individual offenders are most effectively treated when placed in groups with other juvenile sex offenders who can confront and support them; treatment should be primarily focused on the sexual offending behavior and its presumed causes; and that sexual offending is largely a function of deviant sexual interests and social skill and cognitive processing errors that can be effectively addressed by clinicians in controlled, therapeutic environments. The latter includes the assumption that changes observed in therapeutic settings are durable and that they generalize to other environments such as the home, school, and larger community." As Hunter *et al* point out, that approach "may be sufficient for the successful management of lesser disturbed and more motivated youths and families, it is often inadequate in addressing the problems of the high numbers of these youth and families who are more profoundly and pervasively troubled."

Thus, as we move into the second generation of providing treatment to this specialized population, it is becoming increasingly recognized that while the cognitive-behavioral model may be a necessary component of treatment for some juvenile sex offenders, it is very often not sufficient. Youth who have experienced early trauma, including physical and sexual abuse, neglect, domestic violence, and abandonment, often need additional components such as more psychodynamic and experiential approaches. These are often provided in individual therapy, which supplements the core group and in focus groups.

Experiential techniques are especially important in providing services to child perpetrators and to the developmentally delayed offender. However, for most adolescents, individual therapy alone is insufficient to change sexually abusive behavior patterns and should not be used as the exclusive treatment modality. For children with sexual behavior problems there is insufficient information regarding whether or not group therapy is preferential to individual therapy.

While some services typically provided by local Departments of Social Services do occur in the home, the group, individual, and family therapy components of sex-offender-specific treatment typically do not. One promising approach mentioned in the literature that is based on a social-ecological model and derives from systems theory is that of multisystemic treatment (MST). While MST has been assessed in clinical trials with generally delinquent and aggressive youth and shown to be more effective than traditional approaches, its adaptation to the treatment of juvenile sex offenders is still in the preliminary stages and formal assessment of the approach with this population has just begun (Hunter, 2004). Henggeler, Melton, and Smith (2002), in discussing the treatment needs of the serious juvenile offender, which included but was not limited to sexual offenders, stated that "causal modeling studies support the proposition that effective treatments of adolescent behavior should be relatively complex, considering adolescent characteristics as well as aspects of the systems in which adolescents are embedded. Potential treatments should recognize the multiple determinants of antisocial behavior." Henggeler *et al* also commented that the approach to dealing with such youth has led to both "over-intervention," such as out of home placements, and "under-intervention," a failure to provide services. Henggeler suggested that multisystemic therapy provided within a family preservation model of service delivery might be a cost-effective way to provide needed services to these troubled youth while preventing institutionalization and providing better long-term results.

A relevant factor here is the results of the Office of Juvenile Justice and Delinquency Prevention's Study Group on Very Young Offenders (offenders younger than age 13) which found that juveniles who commit serious and violent offenses most often have shown persistent disruptive behavior in early childhood and committed minor delinquent acts when quite young. The Study Group recommended that comprehensive intervention programs be provided to children who persistently behave in disruptive ways and to child delinquents. This population includes children who have engaged in sexually offensive behaviors.

The literature on adult sex offenders from such practitioners as Nicholas Groth and Gene Abel supports that many of the most serious adult sex offenders began acting out even before adolescence, during childhood. Additionally, the work of Cavanaugh-Johnson and others confirms that sexual offending may begin in early childhood. In 1991 Vermont identified 100 sexually aggressive children while the State of Washington identified 691. These numbers did not include children who acted out sexually in non-aggressive ways and were thus considered to be underestimates of the number of sexually offending children.

Barbara Bonner and her colleagues (1990) in their study of children with sexual behavior problems commented that such problems among children are not rare and, in fact, may be much more common than is generally recognized. In that same article they noted that the children with sexual behavior problems in their sample tended to experience more stress in their lives than children in a comparison group and were more disturbed and more pathological. Others who work with sexually acting out children have made similar observations.

The remainder of this document covers basic treatment standards that will apply both to sole practitioners as well as other agencies with which the Department establishes interagency agreements.

Proposed Treatment Approach

The most basic assumption of the Department, which is supported by the literature, is that quality community-based treatment for juvenile sex offenders is contingent on successful legal, juvenile justice, and treatment service coordination. It is the expectation that treatment providers and Case Manager Specialists work collaboratively within a court-mandated framework to provide a unified supervision and intervention team whose primary objective is community safety.

The Department seeks to take a holistic approach to the provision of services to juvenile sex offenders and feels that the best way to do this is through an interagency, collaborative effort in the delivery of services in order to better approach a holistic model. One aspect of the collaborative effort is monthly meetings between the treatment provider, DJS Case Manager Specialist (CMS), parent and any significant others. In some jurisdictions within the State of Maryland elements of this model are already in place. For example, in Baltimore County treatment services for child and adolescent offenders are provided through an intergovernmental agreement between the Department of Juvenile Services and the Department of Social Services. In other jurisdictions the Department contracts with providers of sex offender treatment as well as providers of intensive, in-home, holistic therapy, although these latter contracts are not specifically designed to serve juvenile sex-offenders.

Two factors lead the Department to move in the direction of a more multisystemic approach to the provision of services to this population. One is the increasing level of disturbance and the myriad of problems with which juvenile sex offenders and their families are presenting, a situation that seems to be best approached through a holistic, wraparound model. The second is the Department's mandate to provide services in the least restrictive environment. A holistic approach, particularly with an in-home component, seems to have a better chance of preventing an out-of-home placement than an office-based approach, particularly if this is provided by a sole practitioner. This may be of particular importance as the Department has to provide services to a small but significant group of child delinquents.

In order to address the above concerns and needs, the Department anticipates less funding for services provided by sole practitioners in an office setting, reserving this service for youth assessed as less severely disturbed and less of a risk to the community. It anticipates seeking to establish more collaborative partnerships with other agencies throughout the State, particularly those agencies that can provide in-home services, as it moves in the direction of serving the more disturbed juvenile sex offender in the community while still being cognizant of the need for community safety.

The Department seeks to have a core treatment approach while at the same time encouraging a diverse range of strategies as well as creativity and flexibility among treatment providers. Not every youth who offends sexually is the same and the approach must be individualized to meet the complex needs of the individual client. Mandated treatment is necessary because most youth and their families will not seek treatment or will not see it through to completion without an external requirement to do so. While an internal motivation for treatment improves the prognosis, it is neither necessary for beginning treatment nor a guarantee of success. Research with adult sex offenders is suggesting that denial is not associated with recidivism, but there is no data for juvenile offenders. Therefore, currently, some acceptance of responsibility is usually necessary in order for a youth to be accepted into community-based treatment. No youth is ever kept from treatment because he or she expresses some level of denial. Court leverage and graduated sanctions are necessary to manage youth who are non-compliant with treatment.

It is the position of the Department that in providing treatment services to juvenile sex offenders, community safety is the first priority. When community safety conflicts with the interests of the juvenile and/or his family, the treatment provider must put community safety first. Treatment providers need to report any signs of increased risk to the Case Manager Specialist so that supervision may be increased if necessary.

In the treatment of adolescent sex offenders there are limits on confidentiality. There is no confidentiality between the therapist and the Case Manager Specialist. The limits on confidentiality need to be explained to the juvenile and his family at the start of treatment. Confidentiality as it is normally practiced in therapeutic relationships cannot apply in sex-offender work because it promotes the secrecy that permits sexual offending to occur and may endanger the community.

In order to obtain a complete history of the youth's sexual problem and the risk he or she poses to the community, it is not sufficient to focus merely on the adjudicated offense as this may give a false assessment of risk. As Gray and Pithers (1993) have reported, "In one therapy group for adolescent abusers, the number of reported victims increased 800% during the course of treatment." Any previously unreported incidents of child sexual abuse or new incidents of child sexual abuse must be reported in accordance with Maryland law to the Department of Social Services. A youth who in the context of his treatment reports prior offenses will not necessarily face new charges although that decision is beyond the authority of the Department. However, the

treatment provider is encouraged to make the Office of the State's Attorney and the Juvenile Court aware of the circumstances in which a new disclosure is made. Failure to participate or progress in treatment or dropping out of treatment needs to be immediately reported by the treatment provider to the Case Manager Specialist and the Court.

Treatment services should be appropriate for the developmental and cognitive level of the youth served. Peer groups should not encompass a wide age span of clients. Whenever possible, there should be separate groups for child perpetrators, middle-school age youth, older adolescents, developmentally delayed, and female offenders. Because of the small number of female offenders served by the Department, it may not always be possible to have as wide an array of groups as is possible for young female offenders. Treatment modalities used with children and the developmentally delayed should be appropriate for these populations. It is unlikely that a style that is primarily confrontational and lacks a focus on nurturing will be successful with attachment-disordered youth. Treatment techniques which make use of or encourage humiliation or abuse of the juvenile are expressly forbidden and may be grounds for immediate termination of contract.

While the psychosexual evaluation/risk assessment is necessary prior to the start of treatment, ongoing risk assessment is an important component of treatment. Two risk assessment instruments, the EARASOR and JSOAP II, are currently being validated for risk assessment and may be helpful to the practitioner, especially when viewed in conjunction with other therapy-based considerations.

The Department supports the separation of the offender from his/her victim(s) when the victim(s) is/are a family member(s) and the offense has occurred in the home. The treatment provider should work collaboratively with the Case Manager Specialist and the Department of Social Services to enforce no contact orders and to assure a gradual, therapeutically guided reunification with the family where this is appropriate. No contact includes, unless expressly stated otherwise, no physical, visual, written, or telephone contact. In planning for reunification the needs of the victim take precedence over the needs of the offender. Treatment should deal with this as a consequence of offending. In addition, the DJS Case Manager assists the victim to obtain treatment and, wherever those services may be lacking, advocates for expanded services, more providers and greater provider flexibility.

Parents or guardians of youth who sexually offend must also be included in treatment either through family therapy, multifamily groups, parent groups or any combination thereof. In cases where a youth's parents have no involvement with the youth, as is the case with some youth in foster care, every attempt should be made to include a guardian or some family member or concerned adult in the youth's treatment. While family involvement is important for all youth receiving therapy for sexual offending behaviors, it is critically important for children with sexual behavior problems, whose families often present with multiple problems and often where there are parent-child attachment issues. Additionally, with children who have committed sexual

transgressions, the parent or guardian is important in helping to provide external management of problem behaviors. Very often the family will need assistance in creating a safe, nurturing environment for the child. For child perpetrators the intervention team will most often also include someone from the Department of Social Services. As noted above, for the most disturbed families and offenders, the Department encourages the use of holistic therapy within a wraparound model.

At the same time, parents may need education and empowerment skills. DJS experience indicates that parents may miss obvious signs of sexual misconduct, even after the first incident of abuse. One of the Case Manager Specialist's duties is to ensure parents receive appropriate treatment services.

Goals and Issues to be Addressed in Treatment

For all youth, regardless of the setting in which treatment is provided, the goals of specialized sex-offender- specific treatment are: (1) to stop all sexually abusive behavior; (2) to protect members of society from further sexual victimization; (3) to prevent other aggressive or abusive behaviors which the youth may manifest; and (4) to assist the youth in developing more functional relationship skills.

The following additional issues, as relevant, should be addressed with youth in juvenile sex offender treatment:

- Provide a context for an adolescent sexual offender and his family to explore the patterns of, and factors related to, sexually offensive and maladaptive behaviors. Help the adolescent develop effective strategies to use if he finds himself once again beginning the cycle leading to offending behavior.
- Help the offender admit fully to the sexual offense and accept responsibility for the behavior. Challenge the rationalizations, denials, and minimizations upon which offenders rely to avoid assuming responsibility.
- Develop empathy for the victim of sexual abuse. Develop a more comprehensive emotional awareness in all aspects of their lives.
- If relevant, help the adolescent resolve any issues related to her/his victimization and develop empathy. (Often this work is done in individual, rather than group sessions.)
- Assist the adolescent in developing clear sexual boundaries. Provide new information to challenge rigid, stereotyped ideas about sex roles and intimacy and misinformation about sexuality. A module addressing normal sexual development should be useful.
- Teach the adolescent to cope with stressors and feelings in appropriate, nondestructive ways.
- Facilitate the development of appropriate assertiveness and anger management skills, more effective social skills, and to lessen the isolation often seen in adolescent sex offenders.

Involvement with pornography is always a general risk factor for youth who sexually offend. This is particularly true if the youth is exposed to pornography at an early age. With the easy accessibility of pornography on the Internet, treatment providers should ascertain that the youth's Internet usage is monitored. In cases where it has been ascertained that looking at pornography on the Internet is an issue, computer usage should be supervised. Youth in treatment and their families should be reminded that accessing and transmitting sexually exploitative images of minors on the Internet is a federal and state crime. For minors accessing child pornography might not be an offense depending on the age of the minor and the age of the individual depicted. However, it is always an offense to transmit a sexually exploitative image of a minor even if the minor is transmitting an image of him or her self. A module on Internet safety for adolescents and parents would be highly desirable.

In addition to individual goals, family therapy goals involve the resolution of issues and feelings related to the offending behavior, the development of better communication skills, the resolution of family conflicts related to the offending behavior, and the development of healthy sexual and interpersonal boundaries. Other family therapy goals may involve dealing with issues of loss, divorce, substance abuse, violence, or other factors which may have contributed to the sexual offense and/or caused stress in the family. In sibling incest cases, work toward family reunification, where appropriate, must be done.

Each youth in treatment must have an individual treatment plan, which identifies the issues to be covered, intervention strategies used, and goals to be achieved. At a minimum the treatment plan needs to be revised every 90 days for youth in community based treatment. In order to assure uniformity the Department requires all treatment providers to use the same format when completing treatment plans. (A copy of the form is attached.) In addition, a monthly summary is to be provided to the Case Manager Specialist. In cases where a youth is engaging in risky behaviors or otherwise not being compliant with treatment a more detailed report to the Case Manager Specialist and the Court should be completed in an expeditious manner.

Progress in Treatment and Readiness to Terminate

Progress in treatment or lack thereof, is determined by accomplishment of specific measurable goals and objectives, cooperativeness in treatment, maintenance of control and self-responsibility, changes in thinking, and observable changes in behavior over time. The youth should demonstrate the ability to apply treatment gains to current situations.

Indicators of progress include but are not limited to:

- Acknowledgement of responsibility for offenses without denial, minimization, or projection of blame.

- Behavioral indicators of work toward treatment goals (e.g., less loss of temper, ability to focus on self problems in group, able to take constructive criticism from others, school attendance).
- Ability to understand contributing factors to offending behavior.
- Capacity for victim empathy; demonstration of empathic thinking.
- Ability to manage stress and modulate negative feelings.
- Demonstrated improvement in self-esteem.
- Increases in healthy sexuality and intimacy.
- Positive social interactions; involvement with positive peers.
- Positive family interactions.
- Openness in examining thoughts, fantasies, and behavior.
- Ability to reduce and maintain control of deviant sexual arousal.
- Reduction of deviant fantasies and concurrent increases in healthy, non-abusive, appropriate sexual fantasies.
- Ability to counter irrational thinking and thinking errors.
- Ability to interrupt cycle and seek help when destructive or risk behavior pattern begins.
- Assertiveness and communication skills.
- Positive changes in or resolution of contributing factors to sexually abusive behavior (e.g., cessation of drinking, no longer using pornography).
- Resolution of personal victimization or loss issues.
- Ability to experience pleasure in normal activities.
- Ability to communicate and understand behavior patterns in the treatment setting and connect them to behavior in the home and larger community.
- Family's ability to recognize the risk factors in the youth's cycle and to help their son or daughter manage differently and/or to seek help.

Assessment of progress should not rely solely on offender self-report but should include external forms of observation or verification. In selected cases of older adolescent offenders who are considered at high risk to re-offend, a polygraph examination may be considered. If a polygraph is done, it should be obtained from an independent contractor with experience satisfactory to the Department. (This will usually mean someone with prior FBI, State Police, or Department of Defense training and experience in the administration and interpretation of polygraphs with sexual offenders.)

Clinical Follow Up

Clinical follow up is an important component of community-based treatment just as it is for the youth returning from residential treatment. A gradual decline of contact and support can encourage the youth to continue applying the changes he made in treatment to his daily life. Once it is determined that a youth has successfully completed the peer group phase of treatment, further treatment may be accomplished in individual sessions at gradually increasing intervals of time. Subsequent individual intervention should take a strengths-based approach in that it should entail monitoring the youth's continued application and generalization of skills acquired in treatment as well as any

relapse indicators. These indicators might include return to risky behaviors; use of irresponsible decision making, denial/minimization, substance abuse, pornography and/or deviant fantasies; failure to adjust at home or in placement; and decompensation.

Continuum of Care

In its effort to foster a seamless continuum of care throughout the State of Maryland as well as foster information sharing, the Department plans to institute quarterly meetings comprised of relevant headquarters staff, Case Manager

Specialists, providers of community-based treatment programs, and providers from residential treatment centers (RTC). As appropriate, staff from therapeutic group homes may also be invited to attend. The purpose of these meetings will be to discuss common treatment objectives and to better integrate community and residential programs as youth step-down in treatment (Hunter *et al,* 2004).

One area that might be considered is whether it would be more practical for community-based treatment programs to provide family therapy services in those cases where the family lives too far from the RTC to participate in family therapy there. This might be considered especially when it is anticipated that a youth will go to a particular community-based program for aftercare. Such a system of service delivery will require community and RTCs to work together more collaboratively but has the benefit of a continuous delivery of services as youth move from RTCs back into the community. A second possibility to be examined is the use of teleconferencing for families who cannot attend visitations. Other important areas these meetings might examine would be provision of clinical supervision and case consultation.

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BALTIMORE COUNTY DEPARTMENT OF SOCIAL SERVICES
&
DEPARTMENT OF JUVENILE SERVICES
JUVENILE SEX OFFENDER TREATMENT PROGRAM

Individual Treatment Plan

Client Name: **Date Adjudicated Delinquent:**

D.O.B. **Date of Evaluation:**

Date of First Group Attendance:

Date of ITP:

Members of Treatment Team:

Brief History of Referral Problem:

Current Sexual Behavior:

Living Arrangements:

Medications:

Client Name:

Date:

Modalities of Treatment:

Date Started:	Ongoing:	Date Stopped	Responsible Therapist:

Peer Group:

Multi-family Group:

Individual TX:

Individual Family TX:

Other:

Collateral DSS Contact:

Collateral Agency Contacts: (agency & contact person with telephone number):

Collateral Treatment by Non-DSS Professional:

Other DJS Contacts (formal & informal), Since Presenting Problem:

Juvenile Sex Offender Treatment Program

OVERALL GOALS	SPECIFIC OBJECTIVES	METHODS
Primary Goals		
1. Admit to and take responsibility for sexually abusive behavior. 1 2 3 4 5 No Progress **Much Progress** Rating by therapist. Therapist Comments: _____ _____ _____ _____ _____	• Discontinue Sexually Abusive behavior/related compulsive behavior. • Admit to all sexually abusive behavior. • Take responsibility for sexually abusive behavior.	• Life History • Ongoing self-disclosure re: sex offense • Other
2. Identify, challenge, and change abusive behavior patterns. 1 2 3 4 5 No Progress **Much Progress** Rating by therapist. Therapist Comments: _____ _____ _____ _____ _____	• Identify defense mechanisms and thinking errors used to maintain abusive patterns of thought and behavior. • Reduce defensiveness which interferes with the therapy process. • Identify deviant sexual fantasies, attitudes, and beliefs.	• Group therapy involving disclosure about assaultive/compulsive fantasies, thoughts and behaviors. • Fantasy logs. • Revise cognitive distortions. • Other

Juvenile Sex Offender Treatment Program

3. Identify sexual assault pattern/cycle.

1 2 3 4 5
No Progress **Much Progress**

Rating by therapist.

Therapist Comments:

_____

_____

_____

_____

_____

- Identify precursors to sexual assault (attitudes, emotions, thoughts, behaviors).
- Identify non-sexual motivations underlying sexually assaultive behavior.
- Identify situational factors which may have contributed to offending.
- Identify assault and post-assault thinking and behavior in detail.
- Disclose and discuss sexual fantasies, use of pornography, etc.

- Education on sexual assault (rape, child molestations, incest.
- Group therapy (practicing ongoing self-disclosure, receiving/integrating feedback listening to others, giving feedback).
- Assignments on sexual assault cycle.
- Other

4. Development of victim empathy and understanding of consequences of behavior.

1 2 3 4 5
No Progress **Much Progress**

Rating by therapist.

Therapist Comments:

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- Demonstrate awareness of the impact of abusive/assaultive behavior upon victims.
- Build conscience: develop sense of guilt over wrongdoing.
- Make amends either indirectly or directly.
- Demonstrate ability to empathize with others.

- Education on victim impact lectures, video, reading etc.
- Group therapy.
- Explore one's sexual offense from the victim's perspective).
- Letter to victim (if appropriate).
- Responsibility session with victim (if appropriate).
- Other.

Juvenile Sex Offender Treatment Program

5. Development of victim empathy and understanding of consequences of behavior.

1 2 3 4 5
No Progress **Much Progress**

Rating by therapist.

Therapist Comments:

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- Identify high risk situations (both external and internal).
- Develop interventions to prevent progression of sexual assault cycle.

- Group therapy addressing identification of high risk situations and development of interventions.
- Reoffense prevention education through lectures, workbooks, etc.
- Develop a release plan.
- Identify and develop a support system.
- Other.

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OVERALL GOALS	SPECIFIC OBJECTIVES	METHODS
Primary Goals		
1. Address chemical usage issues. 1 2 3 4 5 No Progress **Much Progress** Rating by therapist. Therapist Comments: _____	• Maintain abstinence from mood-altering chemicals..	• CD therapy group. • Other.
2. Develop responsible, support relationships. 1 2 3 4 5 No Progress **Much Progress** Rating by therapist. Therapist Comments: _____	• Examine current relationships with peers and one's pattern of relating to others. • Improve communication and relationships skills.	• Demonstrate Skills at conflict resolution. • Social Skills training. • Assertiveness training. • Anger management training. • Other

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3. Address own victimization issues/family of origin work.

1 2 3 4 5
No Progress **Much Progress**

Rating by therapist.

Therapist Comments:

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- Education on Family of origin issues.
- Explore dynamics in family of origin.
- Become aware of and begin healing process for one's own victimization.

- Group therapy involving disclosure about family of origin and history of personal victimization.
- Family therapy (if possible and appropriate).
- Individual therapy (if appropriate).
- Other.

4. Address family issue.

1 2 3 4 5
No Progress **Much Progress**

Rating by therapist.

Therapist Comments:

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- Identify family issues, family goals.
- Work toward building family structure that will be supportive of client's treatment.

- Family visits/conferences.
- Family Treatment (if appropriate).
- Assertiveness training.
- Other

Summary: