"The Effective Management of Juvenile Sex Offenders in the Community"

Case Management Protocols

Developed for the Virginia Department of Juvenile Justice

By

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Case Management Protocols

I. Introduction

Case management protocols were developed for the Virginia Department of Juvenile Justice (VDJJ) in support of improving the consistency and effectiveness of community supervision and management of juvenile sexual offenders across the state. The protocols reflect in large part a "best practices" model for community-based management of juvenile sexual offenders piloted by the Norfolk Court Services Unit under the support of a Corrections Program Office grant. The developed protocols will be piloted on a voluntary basis in other selected Virginia Court Service Units during the forthcoming year in an effort to further assess their programmatic viability and effectiveness. Pilot data will inform protocol revision and guide VDJJ in planning for their wider implementation.

VDJJ has generously consented to the broader dissemination of these guidelines to the juvenile sexual offender management field in hope that they will be of assistance to legal and clinical professionals working in other states. It is thought that they may serve as a point of reference to states and local courts in assessing their current management practices, and provide guidance to individual court service units that are attempting to develop specialized case management services for this population. The guidelines are informed by a combination of clinical/legal experience and research on juvenile and adult sexual offenders; however, they have not been validated through research and should be viewed as the professional opinion of the author. The author and the Virginia

Department of Juvenile Justice do not take responsibility for their use in other states and legal jurisdictions.

Use of the protocols should be guided by knowledge of the specific resources of the individual court service unit and larger community, and familiarity with the client population served. They should be used by professionals who have been trained in the specialized legal and clinical management of juvenile sexual offenders, and are most effective when employed in the context of carefully integrated clinical and legal programming (see *National Resource Group Recommended Readings* for more information on juvenile sex offenders and model sex offender programming). It is acknowledged that the protocols reflect optimum levels of legal supervision in a "best practices" model. Many localities may lack the resources for their full implementation, and they may require modification for use in rural areas with a geographically dispersed client population. Further guidance on the appropriate use and limitations of the protocols is provided in *Section D.*

The protocols apply to those youth placed on community supervision following adjudication and sentencing, and youth returning to the community following court-ordered correctional or residential placement. The guidelines were specifically developed to provide decision-support to probation and parole officers in making three determinations: 1) the appropriateness of community care for an individual offender given the nature and severity of his sexual and other psychological and behavioral problems, 2) the type and level of intensity of supervisory and intervention services an offender requires to maintain public safety and ensure his successful rehabilitation, and 3) the offender's readiness for “step-down” or termination of clinical and legal services.

A. Philosophy

Guidelines were developed consistent with VDJJ's adherence to a "balanced approach" in the community-based management of juvenile sexual offenders. This model places equal emphasis on three complementary intervention elements: 1) the need to *maintain public safety*, and protect victims from further harm; 2) the need to *hold offenders accountable* for their offending, and responsible for their future actions; and 3) the need to present offending youth with the *opportunity to receive specialized treatment* designed to reduce their risk of re-offending. Each of these intervention elements is briefly described in the following.

Public Safety and Victim Rights

It is the foremost responsibility of the courts to uphold the right of all citizens of the State to reside in safe and secure communities without fear of harm or victimization. Juvenile sexual offenders who represent an imminent danger to others or who are unable or unwilling to comply with legal and clinical expectations should not be placed in a community environment until such risk and danger has been attenuated. Special precautions must be taken to ensure that the physical safety and psychological security of previously victimized children and women are not compromised by the offending youth's presence in the community, and that he does not have ready access to individuals against whom he might commit new offenses. In support of this goal, all juvenile sexual offenders residing in the community should have carefully crafted supervision and monitoring plans that delineate proscribed and prohibited activities and ensure knowledge of their whereabouts 24 hours a day, 7 days a week. Graduated sanctions (e.g. curfew,

house arrest, electronic monitoring) should be employed commensurate with an individual offender's demonstrated level of risk.

Accountability

It is critical to the maintenance of public safety, and the rehabilitation of juvenile sexual offenders, that they fully acknowledge and assume responsibility for the sexual offenses that they have committed and understand the harm that they have caused others. It is likewise imperative that they assume full responsibility for their future actions. To this end, offenders should be engaged in therapeutic, community service, and victim restitution projects designed to enhance their awareness of the adverse impact of their behavior on victims and their families, and the community at large. These projects should furthermore be designed to help offending youth make amends for their behavior and demonstrate the capacity to become law-abiding, productive members of society.

Treatment

Treatment is an integral component of effective community-based management of juvenile sexual offenders. Treatment provides the youth with the opportunity to gain an understanding of the nature of his sexual behavior problem, its origin and maintenance, and its successful management. This includes the teaching of relapse prevention and self-control skills, and the fostering of pro-social values and competencies. It also includes enhancement of empathy for victims and dedication of oneself to positive life change. Treatment thus serves both the needs of the youth and the needs of the community, and reinforces the goals of public safety and accountability. To this end, all adjudicated juvenile sex offenders residing in the community should be engaged in sex offender-

specific treatment. This includes the provision of clinical aftercare services to youth returning to the community from residential placement. Juvenile sexual offenders should also be provided with ancillary mental health, educational, and vocational services, as required and deemed important to their overall rehabilitation.

B. Approach: Graduated Sanctions Along a Continuum of Care

The developed case management protocols were designed to permit the systematic integration of legal supervisory and clinical interventions so as to most effectively meet the needs of individual offenders and maintain each offender in the least restrictive environment possible. It is recognized that juvenile sexual offenders represent a heterogeneous population and vary as to the nature and severity of their sexual behavior problem(s), the extent to which they manifest other psychological disorders and character disturbance, and their intervention and supervisory needs. It is also recognized that juvenile sexual offenders come from a variety of family backgrounds and are subject to an array of positive and negative peer group and cultural influences.

The heterogeneity of the juvenile sexual offender population, and individual variation in problem manifestation and maintenance, necessitates the availability of a continuum of care and a series of graduated sanctions. Interventions must be tailored to the individual needs of the youth and his parent/guardians, and reflect an understanding of significant intrapersonal and systemic determinants his behavior. In support of assessment of the most appropriate type and level of care for a given youth, profiles have been developed that describe salient features of youth at “Low”, “Moderate”, and “High” levels of risk. These profiles take into consideration the following: the reference sexual offense and offender's criminal history, his psychosexual characteristics and overall

psychological functioning, his peer affiliations and family characteristics, and (where applicable) his past response to sex offender treatment. Profiles have been developed specific to two juvenile sex offender populations: 1) youth placed on probation and supervised and treated in the community; and 2) youth returning to the community following treatment in a Juvenile Correctional Center or residential treatment facility.

Probation and parole officers are encouraged to use empirically supported risk and needs assessment instruments in conjunction with the described profiles to determine an individual offender's supervisory and intervention needs. These include the Department of Juvenile Justice's existent risk assessment instruments and parole supervision matrix (*see Appendix A*). The Department has two generic risk assessment instruments that apply to all youth committed to a Juvenile Correctional Center (JCC): an instrument for assessing risk at the time of commitment (DJJ Form 9260), and an instrument for re-assessing risk post-release (DJJ Form 9336). The former is used to guide initial level of supervision upon release into the community. The latter is used beginning at 90 days following release from the JCC and every 90 days thereafter. The Parole Supervision Matrix delineates levels of supervision based on risk category ("High", "Moderate", and "Low") and length of time following release. Supplementary guidelines have been inserted into the Parole Supervision Matrix to make it maximally helpful in determining the supervisory/intervention needs of juvenile sex offenders being re-integrated into the community following residential care (JCC or private) (see Appendix A). Additionally, a Probation Supervision Matrix has been drafted (see Appendix B).

Probation and parole officers are encouraged to use two additional juvenile sex offender-specific assessment instruments in planning for the supervision and treatment of individual offenders: the *Juvenile Sex Offender Assessment Protocol (J-SOAP)* and the *Child and Adolescent Needs and Strengths-Sexual Development (CANS-SD)(see Appendices B and C).* The *J-SOAP* is a risk assessment instrument that provides ratings of sexual re-offense risk across four scales: "Sexual Drive/Preoccupation", "Impulsive, Antisocial Behavior", "Clinical/Treatment", and "Community Stability/Adjustment". The first two scales are considered "static" (stable traits), and the later two "dynamic" (subject to change). Preliminary data support the internal consistency, inter-rater reliability, and predictive validity of the *J-SOAP*; however, this instrument is in the early stages of development and will require further research before normative data are available and its predictive validity can firmly established.

The *CANS-SD* is a comprehensive juvenile sex offender-specific "needs" assessment instrument. It provides ratings of the youth's functioning in each of the following domains: "Functional Status", "Risk Behaviors", "Mental Health Needs", "Care Intensity and Organization", "Caregiver Capacity", "Strengths", and "Characteristics of Sexual Behavior". The *CANS-SD* emphasizes the identification of both strengths and weaknesses in the functioning of the youth and in his familial and environmental support systems. It is intended to provide guidance to childcare workers, probation and parole officers, and clinicians in identifying salient case management issues and intervention needs. The *CANS-SD* and *J-SOAP* provide complementary assessment information and are best used in combination.

C. "Seamless" Transition From Residential Care

The developed case management protocols were designed to help achieve a "seamless" transition for juvenile sex offenders returning to the community following JCC confinement and treatment. The protocols reflect consideration of whether the youth successfully completed juvenile sex offender specific treatment and his progress in achieving specific treatment goals. They also reflect consideration of his placement needs. In support of these determinations, it is recommended that parole officers participate in a clinical staffing on the youth 90 days prior to his release from the JCC and administer both the *J-SOAP* and *CANS-SD.* This information should be used in aftercare planning and forwarded, along with specific treatment recommendations, to the clinician providing follow-up treatment services. The provided treatment services should be in support of implementation and monitoring of the youth's relapse prevention plan. As such, they should build upon and not duplicate treatment that has been provided in the JCC. The effectiveness of the relapse prevention, and supervisory case management, plans should be continually assessed throughout the period of parole.

D. Appropriate Use and Limitations of the Developed Case Management Protocols and Supervision Matrices

The developed case management protocols are intended to provide general guidance and decision-support to probation and parole officers with juvenile sexual offenders on their caseloads. They are not intended to be a substitute for individual professional judgment or the need for careful and comprehensive criminal investigation or social history gathering. Neither are the developed case management protocols

intended to obviate the need for formal psychosexual evaluation of the youth by a certified sex offender treatment provider.

As previously stated, the protocols should be used in conjunction with established risk and needs assessment instruments—not in “stand alone” fashion. Described levels of risk represent gross demarcations along a continuum of severity; many youth will not fit clearly into one category or another. Criteria within each category should be viewed as examples of the kinds of characteristics/behaviors seen in youth at this overall level of risk. No youth should be expected to meet all criteria within each of the described categories. Furthermore, given youth may reflect "low" or "moderate" risk in one descriptive category and "high" risk in another.

Described “levels of supervision” should only be used as a general framework for determining the supervisory/intervention needs of a juvenile sexual offender at a given level of risk. No two offenders are precisely the same or have exactly the same supervisory/intervention needs. Therefore, all juvenile sex offender case management and treatment plans should be individualized and reflect careful assessment of the specific needs of the youth and the familial, community, and cultural environment in which he lives. Parole Officers should refer to DJJ's "Parole Services Enhancements" document (see Appendix C) for further guidance in appropriate use of the Parole Supervision Matrix.

II. Risk Profiles and Corresponding Levels of Supervision

A. Probation: Community Supervision Following Adjudication

1) "Low Risk"

a) Reference Sexual Offense: The sexual offense(s) was non-violent and did not involve physical force or threats of serious harm to the victim. The sexual offense(s) was non-invasive in nature and did not involve vaginal or anal penetration. The sexual offending is of relatively recent origin (i.e. past 6 months) and limited to 1-3 incidents. Examples: the fondling of the genitalia or buttocks of younger siblings or children for whom the offender was babysitting; unwanted, but non-aggressive touching of a same-age acquaintance.

b) Criminal History: none or minor property or status offenses (e.g. shoplifting)

c) Psychosexual Characteristics: The sexual behavior of these youth may be exploratory in nature and reflect emotional immaturity, poor social skills and competencies, and/or impulsivity. The offenses are typically unplanned and opportunistic. Victims are typically females. The youth is not motivated by paraphilic sexual interests and does not manifest underlying anger or hostility toward females. Sexual interests are age-appropriate. The youth does not have a prior history of sexual offending or inappropriate sexual behavior. The youth acknowledges all of which he has been accused and takes full responsibility for the offending behavior. He appears to be motivated to participate in sex offender-specific treatment.

d) Other Psychological/Behavioral Problems: The youth does not display pervasive, serious, or long-standing psychological and behavioral disturbances. He may show symptoms of mild to moderate depression and/or anxiety. Some youth may have learning and impulse control difficulties, including ADHD and Oppositional/Defiant Disorder. However, the youth does not meet criteria for diagnosis of Conduct Disorder and does not have a history reflective of extensive engagement in aggressive or antisocial behaviors.

e) Family System: The youth does not come from a highly dysfunctional home, however, his family may be experiencing stress associated with economic or childcare problems, divorce, or illness. Parents of the youth are well-meaning, support the need for treatment, and are cooperative with legal and clinical professionals. Parents may lack the resources to properly monitor the youth. Supervision may be a significant problem when the youth has sexually victimized a younger sibling or lives in a high crime neighborhood and shows signs of interest in affiliating with delinquent peers.

f) Previous Sex Offender Treatment: none

g) Appropriateness for Community-Based Care/Prognosis: "good"

h) Commensurate Level of Legal Supervision: see Probation Supervision Matrix

2) "Moderate Risk"

a) Reference Sexual Offense: The sexual offense(s) involved trickery or mild verbal or physical coercion; however, the offense(s) was non-violent in nature, did not result in significant physical injury to the victim, and did not reflect careful planning. The sexual offense may have involved exposure, fondling, oral sexual behavior, or simulated/attempted vaginal or anal intercourse. The victim(s) may have been a younger sibling, extended family member, or acquaintance. Victim(s) was not a stranger. The sexual offending is of limited duration (i.e. 6-12 months), but may have involved multiple episodes. The youth may not admit to all of which he has been accused, and/or may not take full responsibility for the offending; however, he acknowledges the presence of a sexual behavior problem and is willing to participate in treatment.

b) Criminal History: Youth may have a prior history of arrest for non-violent, non-sexual offenses; he typically does not have a history of arrest for sexual offenses.

c) Psychosexual Profile: The sexual behavior of these youth may reflect poor social skills and competencies, especially when the victim is a child. The offender's sexual interests are generally age-appropriate and he is not motivated by paraphilic sexual interests or hostility toward females. However, his capacity for empathy may not be well-developed and he may be impulsive. The offender's sexual offending originated during adolescence.

d) Other Psychological/Behavioral Problems: The youth may show signs of more pervasive psychological and behavioral maladjustment; however, his problems are not of a severe and long-standing nature. Behavior problems typically had an adolescent onset. Impulse control and judgment problems may be evident. The youth may meet criteria for diagnosis of a Conduct Disorder. A history of drug and/or alcohol experimentation may be present; however, he does not have a history of severe drug/alcohol abuse or dependence. The youth may have few friends or affiliate with peers engaging in less serious forms of delinquency.

e) Family System: The youth may come from a moderately dysfunctional home and have a history of maltreatment and/or exposure to antisocial behavior and violence. One or both parents may have substance abuse problems. The parents of the youth may minimize the significance of his problems or feel overwhelmed in attempting to control the youth's behavior. Family resources may be meager and the youth may require out of home placement; however, the youth's parents acknowledge that he has a problem are generally supportive of legal and clinical intervention.

f) Previous Sex Offender Treatment: none

g) Appropriateness for Community-Based Care/Prognosis: "fair" to "good" depending on the extent of the youth's problems, attitude toward treatment, and familial/environmental supports.

h) Commensurate Level of Legal Supervision: see Probation Supervision Matrix

3) "High Risk"

a) Reference Sexual Offense: The sexual offense(s) was invasive and involved threats, deception, or use of physical force. The offense(s) was carefully planned. The offense(s) involved anal or vaginal penetration and/or there were multiple incidents of offending over an extended period of time. The offender used a weapon. The victim(s) suffered physical injury as a result of the sexual crime. The victim(s) was a stranger. The youth shows no or little remorse for his behavior and takes little or no responsibility for his actions. The offender denies all or part of what he has been accused. Expressed motivation for treatment is poor.

b) Criminal History: A history of non-sexual or sexual arrests is present. Offenses were violent or highly aggressive in nature.

c) Psychosexual Profile: The youth shows evidence of long-standing deviant sexual interests or antisocial and aggressive personality traits. Offending against children reflects pedophilic interests and compulsive behavior. Offending against peer or adult females reflects endorsement of rape myths and misogynistic fantasy. The youth has multiple victims and began offending sexually during childhood or early adolescence. The pattern of sexual offenses reflects progression in problem severity and frequency over time. The youth shows evidence of psychopathy and his capacity for empathy appears diminished.

d) Other Psychological/Behavioral Problems: The youth shows signs of pervasive, serious, and long-standing psychological and behavioral

maladjustment. There is a long history of delinquency, including aggressive and violent behavior and substance abuse. Antisocial and aggressive behaviors began in early childhood. The youth does not seem to learn from his mistakes and repeats problematic behavior in multiple environments. Impulse control and judgment problems are poor. The youth meets diagnostic criteria for Conduct Disorder. Social relationships tend to be superficial and/or the youth affiliates with a delinquent peer group; the youth is a social isolate or loner.

e) Family System: Family is moderately to highly dysfunctional. Youth was exposed to violence and antisocial behavior at an early age. Parents have a history of substance abuse or criminal behavior. Parents support the youth's denial of offending or show little motivation for cooperation with legal and clinical authorities.

f) Previous Sex Offender Treatment: none, or unsuccessful completion of community-based sex offender program.

g) Appropriateness for Community-Based Care/Prognosis: "poor" to "guarded" depending on severity and familial/environmental supports.

h) Commensurate Level of Legal Supervision: see Probation Supervision Matrix

B. Parole and Probation: Community Re-entry Following Residential Treatment

1) "Low Risk"

a) Reference Sexual Offense: The sexual offense(s) was non-violent and did not involve physical force or threats of serious harm to the victim. The sexual offending was less invasive and of relatively recent origin (i.e. past 12 months).

b) Criminal History: No prior arrests for sexual offending. No history of arrest for violent crime.

c) Psychosexual Profile: The youth does not show evidence of deviant sexual interests. Offending against children reflects compensatory behavior associated with psychosocial deficits and poor self-esteem. Offending against peer or adult females not reflect endorsement of rape myths or misogynistic fantasy.

d) Other Psychological/Behavioral Problems: The youth does not show evidence of antisocial personality traits or psychopathy. Delinquent behavior emerged in adolescence. Youth does not predominantly associate with a negative or delinquent peer group. Youth may have a history of mental health problems (e.g. mood disturbance); however, he was largely responsive to residential interventions and is currently stable.

e) Family System/Living Environment: Family is emotionally supportive of youth and willing to participate in aftercare programming. Family is willing to receive youth back into home and provide supervision/monitoring. If return to family residence is inappropriate due to offender age, presence of victims, or other extenuating circumstance, then suitable alterative placement is available (e.g. group home).

f) Response to Residential Sex Offender Treatment: Youth successfully completed sex offender-specific treatment program in an average or less than average period of time. Youth did not exhibit significant behavioral problems while in residential care and was cooperative with program staff. Youth did not engage in sexual acting-out during his residential stay and did not engage in acts of aggression or violence. Youth accepts full responsibility for his sexual offending, appears to be remorseful for the behavior, and has empathy for his victim(s). Youth has a well-developed relapse prevention plan and appears fully motivated to comply with therapeutic and legal directives. Youth can clearly articulate his sexual offense cycle, identify high risk factors, and discuss coping strategies. The relapse prevention strategy appears reasonable given the youth's competencies and support systems. Other existent mental health problems were adequately addressed during course of youth's residential stay. Youth was compliant with psychological and pharmacological interventions and demonstrated a positive response to treatment.

g) Educational/Vocational Plans: Youth performs satisfactorily in school and has graduated (or is on schedule to graduate) from high school; and/or youth has successfully participated in vocational programming and has marketable job skills. Youth has history of successful employment.

h) Appropriateness for Community-Based Care/Prognosis: "good"

i) Commensurate Level of Legal Supervision: see Parole Supervision Matrix

2) "Moderate Risk"

a) Reference Sexual Offense: The sexual offense(s) did not involve a high level of violence and the victim(s) did not suffer serious physical injury or harm.

b) Criminal History: No history of arrest for violent crime.

c) Psychosexual Profile: The youth does not show evidence of deviant or paraphilic sexual interests. Offending against children reflects compensatory behavior associated with psychosocial deficits, mood disturbance, and poor self-esteem. Offending against peer or adult females does not reflect well-entrenched rape myths or misogynistic fantasy.

d) Other Psychological/Behavioral Problems: The youth does not meet diagnostic criteria for Antisocial Personality Disorder and does not manifest a high level of psychopathy. Mood disorder and other problems, if present, are responsive to psychological or psychopharmalogical interventions. Delinquent behavior emerged in adolescence and youth does not predominantly associate with a negative or delinquent peer group.

e) Family System/Living Environment: Family is generally emotionally supportive of youth and willing to participate in aftercare programming. Family is willing to receive youth back into home and provide supervision/monitoring; however, family resides in a high-crime neighborhood or parents have poor management skills. If return to family residence is inappropriate due to offender age, presence of victims, or other

extenuating circumstance, then suitable alterative placement is available (e.g. group home).

f) Response to Residential Sex Offender Treatment: Youth successfully completed sex offender-specific treatment program. Youth was reasonably cooperative with program staff. Youth did not engage in sexual acting-out during his residential stay or notable acts of aggression or violence. Youth accepts responsibility for his sexual offending and appears to be remorseful for the behavior. Capacity for empathy may be slightly, but not markedly impaired. Youth has a relapse prevention plan and appears generally motivated to comply with therapeutic and legal directives. Youth can articulate his sexual offense cycle, identify high risk factors, and discuss coping strategies. The relapse prevention strategy appears reasonable given the youth's competencies and support systems. Youth was reasonably cooperative with other mental health interventions (e.g. medication).

g) Appropriateness for Community-Based Care/Prognosis: "fair to "good" depending on severity of problem and adequacy of familial and environmental supports.

h) Commensurate Level of Legal Supervision: see Parole Supervision Matrix

3) "High Risk"

a) Reference Sexual Offense: The sexual offense(s) involved a moderate to high level of force or violence. The victim(s) suffered significant physical

injury or harm as a result of the offender's actions. A weapon was used in commission of the offense. The offending reflected careful planning.

b) Criminal History: The offender has a history of arrest for violent crime. The offender has a previous history of sexual offending, particularly rape of peer or adult females or sexual offenses against prepubescent males.

c) Psychosexual Profile: The youth shows evidence of deviant or paraphilic sexual interests (e.g. pedophilia or sadism). Offending against children reflects long-standing deviant sexual interests and arousal. Offending against peer or adult females reflects well-entrenched rape myths or misogynistic fantasy.

d) Other Psychological/Behavioral Problems: The youth meets diagnostic criteria for Antisocial Personality Disorder (or would except for being under age 18). Youth manifests a moderate to high level of psychopathy. Mood disorder or thought disorder, if present, is not responsive to psychological or psychopharmalogical intervention or you is non-compliant with the same. Delinquent behavior emerged in early childhood and involves multiple forms of antisocial behavior. Youth has history of violent behavior. Youth is a loner or predominantly associates with a negative and delinquent peer group.

e) Family System/Living Environment: Family is not emotionally supportive of youth and/or willing to participate in aftercare programming. Youth is beyond parental control. Placement with family is unadvisable for multiple

reasons (e.g. parental attitude, poor supervision, presence of victims, etc.). Ideal alternative placement is not immediately available.

f) Response to Residential Sex Offender Treatment: Youth did not successfully complete sex offender-specific treatment program, or program completion status was marginal. Youth was resistant and uncooperative with treatment program staff. Youth engaged in sexual acting-out during his residential stay or acts of interpersonal aggression and violence. Youth did not accept responsibility for his sexual offending or did not appear remorseful for the same. Victim empathy significantly lacking; offender minimizes impact of his behavior on the victim or blames the victim or others for its occurrence. Youth does not have a well-developed relapse prevention plan, or cannot articulate the same. Youth cannot describe his sexual offense cycle, identify high risk factors, or discuss coping strategies. The relapse prevention strategy appears uncertain given the youth's limited competencies, inadequate supports, or poor motivation to comply. Youth was non-compliant or non-responsive to interventions for other mental health problems.

g) Appropriateness for Community-Based Care/Prognosis: "poor", youth should be considered at significant risk for relapse.

h) Commensurate Level of Legal Supervision: see Parole Supervision Matrix

III. Case Management Protocols

A. Probation: Community Supervision Following Adjudication

1. Goals:

- Supervised juvenile sex offenders will have no further violations of the law.
- Supervised juvenile sex offenders will be fully compliant with all court orders and terms of probation.
- Supervised juvenile sex offenders will successfully complete a juvenile sex offender-specific treatment program.

2. Special Case Management Responsibilities:

a. Pre-Sentencing

- Refer to a certified sex offender provider for a psychosexual evaluation.
- Transfer sex offender specific information to evaluating clinician, including police report, victim statements, criminal and social histories.
- Meet with youth and parents to explain purpose of psychosexual evaluation and how court will use findings in disposition decision-making. Stress the importance of cooperation.
- Ensure that "risk" and "needs" assessment has been conducted. Ideally, this includes Probation Officer making an in-home visit in conjunction with evaluating clinician or clinical team.

- Participate in post-assessment clinical case staffing devoted to evaluating the offender's appropriateness for community-based care and developing an initial treatment plan.
- Develop comprehensive case management recommendations based on results of psychosexual and other pre-sentence evaluations. The case management recommendations should detail required legal and clinical interventions, and supervisory goals and methods. They should include a copy of the juvenile sex offender-specific treatment plan.
- Formulate report to the court synthesizing the results of the pre-sentence evaluations and making recommendations for disposition. Report should address the offender's appropriateness for community-based care, his designated level of risk for re-offending, and the case management plan. It should include an assessment of the most appropriate living environment for the youth and a description of treatment goals, objectives, and methods, and a timetable for their completion.

b. Post-Sentencing

- Conduct orientation session with youth and family to review court orders and terms of probation.
- Review expectations with regard to compliance with treatment program requirements. Stress the fact that probation officer and therapist will be in regular, on-going communication with one another

and that treatment compliance and progress will be closely monitored and reported to the presiding judge at regularly scheduled court reviews.

- Collaboratively establish with youth, family, and therapist a monitoring/supervision plan that specifies proscribed and prohibited activities, and persons responsible for tracking and reporting compliance and effectiveness.
- Track and carefully document the youth and family's attendance of scheduled therapy sessions, and compliance with monitoring plan and terms of probation.
- Attend major clinical case staffings. Review with therapist the youth and family's progress in achievement of defined therapy goals. Carefully document all findings.
- Maintain collateral contact, as appropriate, with other professionals providing intervention/monitoring services or educational/vocational support. Where applicable, this should include the youth's employer.
- Re-assess "risk" and "needs" on an interval basis--preferably every six months. Use information to evaluate adequacy of case management and treatment plans, achievement of intervention goals, and youth's readiness for "step-down" in intensity of care.
- Submit regular formal reports to the presiding judge describing the youth's progress in treatment, achievement of specific legal and clinical goals, and continued appropriateness for community-based

care. Keep judge apprised of anticipated time to completion of treatment program. Where possible and appropriate, have above information processed in formal court reviews with youth and family in attendance.

c. Point of Completion of Active Phase of Treatment (or Administrative Discharge)

- Meet with therapist, youth, and family to ascertain achievement of clinical objectives and readiness for "step-down" in intensity of clinical and legal intervention. Use "risk" and "needs" assessment data to support decision-making. Review criteria for readiness for "step-down" in intensity of care (see Appendix). Discuss recommended changes in case management plan and associated goals and timetable for their achievement. Inform judge of recommendation to "step-down" intensity of care and seek approval.
- In cases of discharge due to non-compliance, carefully document specific problems that led to decision to terminate clinical services. Formulate a report to the presiding judge describing the chronology of these problems and attempts to rectify them. As appropriate, make recommendations for violation of probation and placement at a higher level of care.

d. Point of Termination of Services

- Review with therapist the youth's achievement of treatment goals and compliance with terms of probation. Use "risk" and "needs"

assessment data to support decision-making. Review criteria for termination of services (see Appendix).

- Meet with youth and family to seek their input into determination of readiness for termination of services.
- Submit report to court regarding recommendation for termination of services.

3. Parent/Caretaker Responsibilities

- Provide supervision of youth so that he can comply with probation conditions.
- Provide an emotionally supportive and healthy living environment for youth devoid of exposure to violence and antisocial or sexually inappropriate behavior. Ensure that the youth does not have access to pornographic materials in the living environment.
- Encourage youth to fully participate in treatment until successful completion of program has been attained. Participate in family therapy and parent psycho-educational support group, as requested by therapist and directed by the court.
- Provide financial support for treatment as determined appropriate by the court.
- Promptly and accurately report violations of terms of probation, or non-compliance with treatment plan or court orders, to the supervising probation officer and therapist.

- Comply with general probation conditions.

4. Minimum Contact Requirements: See *Probation Supervision Matrix* for guidance in determination of type and intensity of services based on assessed risk.

5. Criteria for Readiness for "Step-down" in Level of Supervision

   - Offender (and parents where applicable) has attended all scheduled therapy sessions (except for excused absences) and has demonstrated a positive attitude toward treatment.
   - Offender (and parents where applicable) has been fully compliant with therapeutic directives and is judged to be making good progress in the attainment of treatment goals.
   - Offender acknowledges all sexual offenses of which he was convicted and takes full responsibility for his behavior.
   - Offender appears remorseful for his sexual offending and has empathy for his victim(s).
   - Offender has a well-developed relapse prevention plan and has a good understanding of his sexual offense cycle and high risk factors. Offender has not engaged in high risk behaviors or thinking patterns for a minimum of 90 days.
   - Offender has been fully compliant with all court orders and terms/conditions of his probation/parole.

6. Criteria for Termination of Services

- Offender takes full responsibility for his sexual offending and acknowledges all behaviors for which he was convicted.
- Offender appears genuinely remorseful for his sexual offending and has empathy for his victim(s)
- Offender was fully cooperative with his therapist(s) and compliant with therapeutic directives.
- Offender successfully completed the treatment program in its entirety.
- Offender understands his sexual offense cycle, including the thoughts, feelings, and events that lead to his sexual acting-out.
- Offender sufficiently understands his risk factors for re-offending, and can identify and successfully employ coping and management skills to maintain control over his behavior.
- All of the offender's psychiatric and behavioral problems were adequately addressed, and he displays overall emotional maturity and behavioral control.
- Offender was fully compliant with all legal directives and prohibitions.
- Offender's living environment is conducive to maintenance of control over his sexual behavior, and other psychiatric and behavioral, problems.
- Offender is gainfully employed or enrolled in an educational/vocational program that offers the promise of developing competitive job skills.

- Offender has positive peer and familial relationships that support him in maintaining a healthy lifestyle and refraining from future sexual acting-out and delinquent behavior.

B. Parole and Probation: Residential Placement

1. Goals:
    - Supervised juvenile sex offenders will have no further violations of the law.
    - Supervised juvenile sex offenders will be fully compliant with all court orders and terms of probation/parole.
    - Supervised juvenile sex offenders will successfully complete a juvenile sex offender-specific treatment program.
    - Supervised juvenile sex offenders will successfully complete a relapse prevention aftercare program following discharge from residential care.

2. Special Case Management Responsibilities:
    a. Residential Placement
        - Following sentencing, meet with youth and his family to review the terms of his probation/parole. Discuss nature and purpose of residential placement (commitment) and stress importance of successfully completing treatment program.
        - Provide supplementary background information to residential treatment provider, including criminal and social history,

psychological and psychosexual evaluations, and terms of probation/parole.

- Provide input into formulation of treatment goals and obtain copy of offender's individualized treatment plan.
- Provide assistance in arranging necessary ancillary support services for youth's family during the time of his residential stay. This should include helping the parents identify and gain access to treatment services for victimized family members.
- Participate in quarterly clinical case staffings. Meet "face-to-face" with youth following each clinical staffing to review presented reports and his overall progress in achieving treatment goals. Address any significant behavioral/attitudinal problems that have arisen.
- Place residential treatment program progress reports in case file. Report to the court the youth's progress in treatment and any serious violations of treatment program/facility rules.
- Maintain on-going contact with youth's family to monitor their level of involvement in youth's treatment, and support for his successful completion of the residential treatment program. Ensure that family is fully apprised of his progress in treatment and any significant behavioral/attitudinal problems that have arisen.
- At least *90 days prior* to the youth's discharge from residential care, meet with his therapist/treatment team to review his readiness for "step-down" to community-based care. Re-administer "risk" and

"needs" assessment instruments, as appropriate, to assist in determination of readiness for discharge and aftercare needs. Determine placement needs and advisability of a return to the home of the family. Work collaboratively with treatment provider to formulate a comprehensive aftercare plan that addresses the following: continued support for control of his sexual behavior problem, treatment of ancillary mental health problems (e.g. substance abuse), and educational/vocational training (or employment).

- Ensure that the youth has a comprehensive relapse prevention plan that details pertinent aspects of his sexual assault cycle, including "high risk factors" and coping strategies.
- Arrange for juvenile sex offender-specific aftercare, preferably with a state certified treatment provider. Provide provider with copies of all pertinent court and treatment facility records, including the youth's relapse prevention plan. Obtain an appointment date for youth's first meeting with community-based treatment provider following discharge.
- Meet with youth (and family where appropriate) prior to his release to review his relapse prevention plan; discuss aftercare programming and terms of his probation/parole. Inform youth and family/caretaker of appointment time/date for first meeting with community-based treatment provider. Obtain youth and family/caretaker's input into a community supervision plan that details structured

therapeutic/educational/vocational/social activities and the monitoring of his whereabouts 24 hours a day, 7 days a week. Discuss additional sanctions, as appropriate (e.g. curfew, electronic monitoring, etc.).

- Review community supervision plan with community-based treatment provider and obtain input.

b. Post-Release From Residential Care

- In first "face-to-face" meeting with youth and family/caretaker following release, review terms of probation/parole and the relapse prevention and community supervision plans. Emphasize expectations with regard to compliance with all aspects of the above. Stress the fact that probation officer and therapist will be in regular, on-going communication with one another and that treatment compliance and progress will be closely monitored and reported to the presiding judge at regularly scheduled court reviews.
- Maintain on-going contact with youth and family, as outlined in Case Management Plan and consistent with judged level of risk (see *Parole Supervision Matrix*). Maintain careful documentation of youth's attendance of scheduled therapy sessions, and compliance with supervision/monitoring plan and terms of probation/parole.
- Attend all clinical case staffings. Review with youth and family/caretaker his progress in achievement of specific therapy goals. Document findings.

- Maintain collateral contact, as appropriate, with other professionals providing intervention/monitoring services or educational/vocational support. Where applicable, this should include his employer.
- Re-assess "risk" and "needs" on an interval basis--preferably every six months. Use information to evaluate adequacy of case management and treatment plans, achievement of intervention goals, and youth's readiness for "step-down" in intensity of care.
- Submit regular formal reports to the presiding judge describing the youth's progress in treatment, achievement of specific legal and clinical goals, and continued appropriateness for community-based care. Keep judge apprised of anticipated time to completion of aftercare program. Ideally, the above should be processed in formal court reviews attended by the youth and his family/guardian.

c. Point of Termination of Services

- Confer with community-based therapist regarding youth's readiness for discharge. Review youth's achievement of treatment goals and compliance with terms of probation/parole. Use "risk" and "needs" assessment data to support decision-making. Review criteria for termination of services.
- Meet with youth and family to seek their input into determination of readiness for termination of services.
- Submit report to court regarding recommendation for termination of services.

3. Parent/Caretaker Responsibility

- Support youth during course of residential stay. Participate in family therapy and parent-support groups, as requested by treatment staff and ordered by court.
- Following release from residential care, provide supervision of youth so that he can comply with probation/parole conditions.
- Following release from residential care, provide emotionally supportive and healthy living environment for youth. Ensure that the youth is not exposed to violence, antisocial behavior, or sexually inappropriate behavior. Ensure that the youth does not have access to pornographic materials in the place of residence.
- Encourage youth to fully participate in treatment until successful completion of aftercare programming has been attained. Participate in family therapy and parent support group activities, as requested by therapist and directed by the court.
- Provide financial support for aftercare treatment as determined appropriate by court.
- Promptly and accurately report violations of terms of probation, or non-compliance with treatment plan or court orders, to the supervising probation officer and therapist.
- Comply with general probation/parole conditions.

4. Minimum Contact Requirements: *See Parole Supervision Matrix*.

5. Criteria for Readiness for "Step-down" in Level of Supervision

   - Offender (and parents where applicable) has attended all scheduled aftercare therapy sessions (except for excused absences) and has demonstrated a positive attitude toward his follow-up treatment.
   - Offender (and parents where applicable) has faithfully followed his relapse prevention plan, including avoiding frequenting high risk environments or engaging in behaviors or thinking patterns that could lead to a lapse or relapse. Offender has not engaged in high risk behaviors or thinking patterns for a minimum of 30 days.
   - Offender has been fully compliant with all court orders and terms/conditions of his probation/parole.

6. Criteria for Termination of Services

   - Offender successfully completed juvenile sex offender-specific residential and community-based aftercare programming.
   - Offender takes full responsibility for his sexual offending and acknowledges all behaviors for which he was convicted.
   - Offender appears to have genuine remorse for his sexual behavior and empathy for his victim(s).

- Offender has faithfully adhered to the tenants his relapse prevention plan since his release from residential care. This includes the following. He avoided external circumstances that would have placed him at elevated risk for sexual re-offending (e.g. frequenting public places that draw children). He refrained from engagement in behavior that may have directly or indirectly increased his risk of re-offending (e.g. drinking). He showed an inclination and capacity to utilize agreed upon coping strategies to maintain control over his sexual behavior? He reported to his therapist and the supervising probation/parole officer any errant behaviors or thinking patterns that may have led to a "lapse" or the potential for the same.
- Offender was fully cooperative with his therapist(s) and compliant with all therapeutic directives.
- Offender successfully completed any ordered ancillary aftercare programming (e.g. substance abuse treatment).
- Offender's psychiatric and behavioral problems were adequately addressed, and he displays overall emotional maturity and behavioral control?
- Offender was fully compliant with legal directives and prohibitions.
- Offender's living environment is conducive to maintenance of control over his sexual behavior, and other psychiatric and behavioral, problems.
- Offender is gainfully employed or enrolled in an educational/vocational program that offers the promise of developing competitive job skills.

- Offender has positive peer and familial relationships that support him in maintaining a healthy lifestyle and refraining from future sexual acting-out and delinquent behavior.

Appendix A

Probation Supervision Matrix

Juvenile Sex Offender Probation Supervision Matrix			
	High Risk*	Moderate Risk*	Low Risk*
First 90 days	Level 5	Level 4	Level 3
Months 4 – 6	Level 4	Level 4	Level 3
Months 7 -12	Level 4	Level 3	Level 2
Months 13 -18	Level 3	Level 3	N/A / Level 2
Months 19 -24	Level 2	N/A / Level 2	N/A / Level 1
Beyond Month 24	N/A / Level 1	N/A / Level 1	N/A / Level 1
Probation Period	24 - 30 Months	18 - 24 Months	12 - 18 Months

*Risk classification based on review of all assessment and evaluation results including DJJ Risk Assessment, J-SOAP, CANS, clinical psychosexual evaluation, and Sex Offender Risk Checklist

Face – to – face contacts may include those made by the probation officer as well as other professionals providing essential treatment and/or supervision services as specified in the definitions.

Define telephone contacts separately, if desired

Minimum levels – higher levels may be specified in the Supervision Plan

Level 5 Supervision: Intensive Supervision
- Minimum of 3 to 5 contacts per week (minimum 3 contacts per week by CSU staff)

Level 4 Supervision: Enhanced Supervision
- Minimum of 2 to 4 contacts per week (minimum 2 contacts by CSU staff)

Level 3 Supervision:
- Minimum of 1 contact per week (contact made by CSU staff)

Level 2 Supervision:
- Minimum of 1 contact every other week (both contacts made by CSU staff)

Level 1 Supervision:
- Minimum of 1 contact per month (contact made by CSU staff)

Appendix B

Parole Supervision Matrix

Juvenile Sex Offender Parole/Post-Residential Treatment Supervision Matrix			
	High Risk*	Moderate Risk*	Low Risk*
First 30 days	Level 5	Level 5	Level 4
Months 2 – 3	Level 5	Level 4	Level 3
Months 4 – 6	Level 4	Level 3	Level 2
Months 7 – 9	Level 3	Level 2	N/A / Level 2
Months 10 – 12	Level 3	N/A / Level 2	N/A / Level 1
Month 12 -15	N/A /Level 2	N/A / Level 1	N/A / Level 1
Beyond Month 15	N/A /Level 1	N/A / Level 1	N/A / Level 1
Parole Period	12 - 18 Months	9 - 15 Months	7 - 12 Months

*Risk classification based on review of all assessment and evaluation results including DJJ Risk Assessment, DJJ Parole Risk Re-Assessments, J-SOAP, CANS, clinical psychosexual evaluation, and Sex Offender Risk Checklist

These contact levels are equivalent to probation (except measured by month not week) and are minimum levels – higher levels may be specified in the Supervision Plan

Level 5 Supervision:
- Minimum of 12-20 contacts per month (minimum 12 contacts by CSU staff)

Level 4 Supervision:
- Minimum of 8-16 contacts per month (minimum 8 contacts by CSU staff)

Level 3 Supervision:
- Minimum of 4 contacts per month (contact made by CSU staff)

Level 2 Supervision:
- Minimum of 2 contacts per month (contact made by CSU staff)

Level 1 Supervision:
- Minimum of 1 contact per month (contact made by CSU staff)

Additional Considerations

Probation and Parole Officers are encouraged to consider the following additional stipulations and supervisory elements:
- Strict adherence to a curfew
- 24 hour supervision schedule monitored by the parent and Probation/Parole Officer

- Weekend Incentive and Sanction Program
- Consistent communication with provider of sex offender treatment, and other providers
- Development of special conditions consistent with offense history and needs
- Parents must attend all prescribed therapy sessions
- Electronic monitoring (selective use with certain "high risk" youth).

"Step-Down" to Lower Level of Supervision

Step-down to a lower level of supervision should be contingent on the youth's full compliance with all legal and clinical directives, and demonstration of attainment of specific therapeutic goals. The latter should reflect consultation with the sex offender treatment provider and consideration of stage of treatment. It is particularly important in working with juvenile sex offenders that youth not be stepped down to "Level 2" or below until they have developed (and are behaving in compliance with) a relapse prevention plan, and are demonstrating enhanced victim empathy and appropriate judgment and impulse control.

Appendix C

Parole Supervision Enhancements

To obtain the Parole Supervision Enhancements document, please contact:

Department of Juvenile Justice
700 East Franklin Street, 4th Floor
Richmond, Virginia 23218
Phone: 804-371-0700
Fax: 804-371-0773