

► Overview

Treatment has been a consistent feature of adult and juvenile sex offender management efforts for decades. However, the underlying structure, delivery, and philosophies of sex offender treatment in the field have been much less consistent. Early treatment methods varied widely, based on theories and techniques that ranged from psychodynamic to strict behaviorism (see Laws & Marshall, 2003 for a review). Programming then became grounded within a cognitive-behavioral framework, and eventually incorporated an emphasis on relapse prevention (see Marshall & Laws, 2003). Even today, sex offender treatment continues to evolve. Indeed, the relapse prevention model, which had been standard practice for many years, has become less influential in favor of more contemporary models of treatment that take into account multiple “pathways” to offending for adults and juveniles (see, e.g., Hunter, 2006; Hunter, Figueredo, Malamuth, & Becker, 2003, 2004; Ward & Hudson, 1998, 2000; Ward & Siegert, 2002; Ward, Polaschek, & Beech, 2006).

Despite these ongoing transformations within the sex offender treatment field, one feature has remained constant – the desire and expectation that through intervention, problem sexual behaviors will be reduced and community safety will be enhanced. And current research suggests that, depending upon the underlying theoretical model and the specific techniques used, some forms of treatment come closer to

meeting that goal than others (Aos, Miller, & Drake, 2006; Hanson et al., 2002; Reitzel & Carbonell, 2006; Walker, McGovern, Poey, & Otis, 2004). Therefore, as stakeholders begin to critically consider the ways in which treatment is approached within their jurisdictions, the following should be taken into account:

- Availability, capacity, and accessibility of programs along a continuum of care;
- Guiding frameworks and goals;
- Modes, methods, and targets of intervention;
- Treatment planning, including documentation of progress and completion;
- Specialized knowledge and experience for treatment providers; and
- Support from key stakeholders throughout the system.

► Availability, Capacity, and Accessibility

Because adult and juvenile sex offenders are diverse populations with varied levels of risk and needs, jurisdictions should have a continuum of treatment services available, ranging from an array of options in the community, to services in group homes and moderate care facilities, and ultimately including treatment in secure correctional or residential facilities (see, e.g., Bengis, 1997; Berenson & Underwood, 2000; Hunter, Gilbertson, Vedros, & Morton, 2004; Marshall et al., 2006a; Schwartz,

2003). Keeping in mind that interventions are more likely to reduce recidivism when matched to the level of risk posed by individuals, community-based sex offender treatment is more likely to be effective for low risk offenders; more intensive treatment within correctional or juvenile justice facilities is best reserved for those who pose a higher risk for recidivism (see, e.g., Berenson & Underwood, 2000; Friendship, Mann, & Beech, 2003; Gordon & Nicholaichuk, 1996; Mailloux et al., 2003; Nicholaichuk, 1996).

A continuum of care is particularly important when considering treatment and placement options for juvenile sex offenders (Bengis, 1986, 1997; Hunter, 2006; Hunter et al., 2004). Juvenile facilities tend to be over-relied upon for treating juvenile sex offenders, even when youth pose a low risk, often because of a lack of dedicated treatment capacity in communities (Hunter et al., 2004). Yet research indicates that when delinquent youth are placed together for intervention purposes, recidivism may potentially increase because of the impact of negative peer influences (see Dodge, Dishion, & Lansford, 2006). Moreover, no evidence suggests that this level of care is more effective than other settings in reducing recidivism. On the other hand, family- and community-based interventions with juvenile sex offenders have very positive outcomes (see, e.g., Borduin & Schaeffer, 2002; Hunter et al., 2004; Saldana, Swenson, & Letourneau, 2006).

Ideally, when making decisions about levels of care, the courts and other justice professionals

will have the benefit of pre-sentence investigations and comprehensive psychosexual evaluations that specifically address risk and needs in a valid and reliable manner. (For additional information about the use of assessments to inform decisionmaking, see the Assessment section of this protocol.) Following the initial placement, should circumstances warrant (e.g., significant increases or decreases in risk), policies and procedures should be in place that afford correctional and juvenile justice agencies the latitude to make informed adjustments to the level of care accordingly. To the extent possible, treatment settings for juveniles should also take into account the least restrictive alternative, proximity to the home and community, and family strengths and needs.

Prison-Based Sex Offender Treatment

The majority of states offer some form of prison-based sex offender treatment in one or more of their facilities (West, Hromas, & Wenger, 2000). In some jurisdictions, correctional agencies are legislatively or otherwise mandated to maintain treatment programs and, in some instances, legislation requires sex offenders to participate in these programs in order to be considered for conditional release or parole. Regardless, although prison-based sex offender treatment programs are generally available, their actual capacity may be quite limited (see, e.g., Gordon & Hover, 1998; West et al., 2000). These capacity concerns, coupled with the ever-increasing numbers of convicted sex offenders entering prisons (Harrison & Beck, 2006), mean that it will be a greater challenge to ensure that all of the sex offenders who can benefit from prison-based treatment will be able to access it.

A CONTINUUM OF CARE IS PARTICULARLY IMPORTANT WHEN CONSIDERING TREATMENT AND PLACEMENT OPTIONS FOR JUVENILE SEX OFFENDERS.

To increase availability, capacity, and accessibility, program administrators and staff have begun to develop a range of prison-based sex offender-specific interventions that vary in nature and intensity (see, e.g., Gordon & Hover, 1998; Marshall et al., 2006b; Schwartz, 2003). This may include services such as psychoeducational classes, “outpatient” or “call out” groups, or intensive treatment programs such as therapeutic communities (see, e.g., Gordon & Hover, 1998; Marshall et al., 2006b; Schwartz, 2003; West et al., 2000). When a range of services exists, sex offenders should be channeled into those services based on their assessed level of risk. This increases the potential impact of interventions while maximizing limited resources (see, e.g., Gordon & Hover, 1998; Mailloux et al., 2003; Marshall et al., 2006b; Nicholaichuk, 1996; Schwartz, 2003).

As jurisdictions attempt to expand the reach of prison-based sex offender treatment, policies should be established that:

- Define eligibility criteria and any mandates (e.g., legislative, agency) for participation;
- Make available a range of prison-based sex offender treatment services that vary in intensity;
- Provide all incarcerated sex offenders with information about the available sex offender treatment services and how to access such services if they are interested;
- Delineate a formal, assessment-driven process by which individual sex offenders are matched to intensity of services based on risk level (e.g., higher risk offenders receive more intensive services);
- Prioritize access into sex offender treatment based on release dates;
- Reassess the level of interest of those individuals who are not participating in any of the available services and encourage them to engage in treatment; and

- Transition sex offenders to lower levels of care or security when they have progressed sufficiently in treatment.

Facility-Based Treatment for Juveniles

Within the juvenile justice system, well over one-third of publicly operated institutions and facilities are over capacity (Snyder & Sickmund, 2006). Indeed, during the past several years, state-operated facilities experienced a 20% increase in the placement of juvenile sex offenders and privately-operated facilities saw an increase of 68% (Snyder & Sickmund, 2006). This surge in the placements of juvenile sex offenders is noteworthy given the decrease in facility placements for other justice-involved youth (Snyder & Sickmund, 2006). It is not known whether the increase is a function of reduced availability and/or capacity of juvenile sex offender-specific programming within state-operated facilities, a greater capacity for such programming within the privately-operated placements, or both. Nonetheless, the substantial increase in juvenile sex offenders entering both public and private juvenile facilities will likely pose challenges with respect to treatment capacity.

For those agencies and facilities who receive juveniles in need of residential or other facility-based sex offender treatment, several factors should be considered as a means of balancing the treatment needs of these youth with the limited specialized treatment capacity (see, e.g., Bengis, 1997; Bengis et al., 1999; Berenson & Underwood, 2000; Wieckowski, Waite, Pinkerton, McGarvey, & Brown, 2004). For example, clear policies, procedures, or guidelines should be developed in order to:

- Establish the specific admission and exclusionary criteria to ensure that the

secure/residential structure is appropriate based on the risk and needs posed by the juvenile;

- Consider facility placements that take into account proximity to the juvenile's home community and that are accessible to families;
- Ensure a range of juvenile sex offense-specific treatment options exists within the system (e.g., secure, moderate, low);
- Delineate a process by which juvenile sex offenders receive the intensity of interventions that is commensurate with their assessed level of risk and needs;
- Develop specific, measurable, risk management-related goals that will allow juveniles to be safely transitioned for continued services in a less restrictive setting, including the community; and
- Immediately recommend transfer to less restrictive alternatives when juveniles no longer require the current level of structure or care.

Community-Based Programs for Adult and Juvenile Sex Offenders

Throughout the country, community-based sex offender treatment programs for adults and juveniles far outnumber prison-based and other residential treatment programs (McGrath, Cumming, & Burchard, 2003). This apparent increase in availability and capacity is a positive trend, especially because some research suggests that community-based treatment has a greater impact than institutional treatment with adults, and because family- and community-based interventions are among the most promising interventions for juvenile sex offenders (see, e.g., Aos, Phipps, Barnoski, & Lieb, 2001; Aos et al., 2006; Lösel & Schmucker, 2005; Reitzel & Carbonell, 2006; Worling & Curwen, 2000).

While increased availability and capacity is desirable, larger numbers of programs and providers may pose challenges related to the assurance of quality, integrity, consistency, and effectiveness of community-based treatment services. To address this concern, jurisdictions may wish to establish formal mechanisms to ensure that minimum expectations or standards for treatment are met and maintained. Some states have developed statewide standards or formal certification processes (e.g., Colorado, Illinois, Tennessee, Texas, Utah), and professional membership organizations and other interested entities have also proposed guidelines for treatment (see, e.g., AACAP, 1999; ATSA, 2005; NAPN, 1993). Another strategy to promote quality and consistency can be implemented when criminal and juvenile justice agencies contract with community-based treatment providers. In these instances, specific requirements can be outlined in the request for proposals, including minimum provider qualifications, the program model to be used, expectations for quality assurance, and requirements for tracking outcomes.

The following factors may also be helpful as stakeholders critically examine the community-based sex offender treatment programs that exist in their jurisdictions:

- *Scope of Practice.* With increased demands for specialized treatment, providers may be asked to expand the scope of their existing services to accommodate new referrals. This could apply to treatment providers that do not currently provide services to sex offenders, or to sex offender treatment providers who focus only on a specific subgroup of sex offenders (e.g., adult males, juvenile males). Without the requisite training, experience, and expertise, providers may be ill-equipped to provide treatment to those referrals. Providers must be willing to acknowledge

the limitations of their training and expertise, set clear boundaries for the types of clients that they can serve, and make referrals to qualified treatment providers.

- *Access for Non Justice-Involved Individuals.* Traditionally, sex offender treatment programs are designed to serve individuals who have been adjudicated or convicted. In some instances, programs may actually exclude individuals who have not been formally processed through the courts. However, a number of adults and juveniles who have engaged in sexually abusive behavior never proceed through the court process and instead are managed through child welfare or other social/human services agencies. Given the overarching goal of preventing victimization, treatment should be accessible regardless of an individual's status in the system. Access should also extend to other individuals who may not have been detected, or even those who have never engaged in sexually abusive behavior but are concerned about their potential to do so.
- *Demonstrated Commitment to Collaboration.* The safety of victims and communities is dependent upon key stakeholders involved in community management of sex offenders working together effectively (see, e.g., ATSA, 2005; Carter, Bumby, & Talbot, 2004; English, Pullen, & Jones, 1996; NAPN, 1993). This requires treatment providers to partner with supervision officers, family therapists, child welfare professionals, and others to share assessment information, discuss levels of risk and needs, review treatment progress and compliance with treatment and supervision expectations, and coordinate day-to-day case management efforts to ensure that critical decisions are made based on the most current and comprehensive information. This commitment must also

include mechanisms for timely information-sharing to ensure that treatment providers and others are poised to intervene when necessary.

- *Continuity of Interventions Along the Continuum.* Many individuals enter community-based treatment programs following release from institutional or residential settings. Conversely, some individuals participating in community-based treatment will be placed in a correctional facility or residential program, either because of a new criminal or delinquent offense, revocation of conditional release, repeated probation violations, or other significant changes in risk or needs. In these scenarios, continuity of care is critical to ensure that offenders are able to continue in treatment as they move in either direction. This continuity should prevent unnecessary gaps in treatment and duplication of treatment efforts, both on the part of offenders and providers. As discussed below, this is contingent not only on assessment-driven treatment planning and critical information-sharing about treatment progress, but also on the use of a common framework or model of treatment.

► Questions: Adult Sex Offenders

Availability, Capacity, and Accessibility

Continuum of Care

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|----|------------------------|-----------------------|--------------------------|-----------------------|--|
| 1. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Does a range of treatment options exist for sex offenders, from community- to prison-based services? |
| 2. | | | | | Are sentencing/placement decisions for sex offenders informed by: |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Pre-sentence investigations?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Psychosexual evaluations?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Validated, sex offender-specific risk assessment tools?</i> |
| 3. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are sentencing/placement decisions for sex offenders informed by the assessed risk level (e.g., secure correctional facilities for higher risk offenders)? |
| 4. | <input type="radio"/> | | | <input type="radio"/> | Are policies or procedures in place that afford correctional agencies the latitude to make well-informed adjustments to the level of care based on significant changes (e.g., increases or decreases) in sex offender risk? |

Prison-Based Sex Offender Treatment

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|---|
| 5. | <input type="radio"/> | | | <input type="radio"/> | Does legislation or do other mandates require corrections agencies to offer prison-based sex offender treatment? |
| 6. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are sex offenders required to participate in prison-based sex offender treatment? |
| 7. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are parole/early release considerations for sex offenders contingent upon their successful participation in prison-based sex offender treatment? |
| 8. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is sex offender treatment available within correctional facilities? |
| 9. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | During intake/reception, are sex offenders notified about the availability of sex offender treatment services and the ways to access such services? |
| 10. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are sex offenders able to access prison-based sex offender treatment in a timely manner? |

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|--|
| 11. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is the capacity of prison-based sex offender treatment programs sufficient to allow sex offenders to complete treatment prior to their release date? |
| 12. | <input type="radio"/> | | | <input type="radio"/> | Do standards or guidelines outline the ways in which prison-based sex offender treatment should be delivered? |
| 13. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is a range of sex offender treatment services available within correctional facilities (e.g., psychoeducational services, intensive programming)? |
| 14. | <input type="radio"/> | | | <input type="radio"/> | Do policies or procedures delineate a process by which sex offenders are assigned to prison-based sex offender treatment based on assessed level of risk (intensive programming for higher risk sex offenders)? |
| 15. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | In practice , are sex offenders assigned to prison-based sex offender treatment based on assessed level of risk (intensive programming for higher risk sex offenders)? |
| 16. | <input type="radio"/> | | | <input type="radio"/> | Do policies or procedures delineate a process for prioritizing sex offenders for prison-based sex offender treatment based upon presumed release dates? |
| 17. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | In practice , are sex offenders prioritized for prison-based sex offender treatment based upon presumed release dates? |
| 18. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are sex offenders who are not participating in prison-based treatment reassessed periodically to re-evaluate their level of interest and to encourage them to engage in treatment? |
| 19. | <input type="radio"/> | | | <input type="radio"/> | Do policies or procedures allow sex offenders to be transitioned to less secure settings after progressing in treatment? |
| 20. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | In practice , are sex offenders transitioned to less secure settings after progressing in treatment? |
| 21. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do prison-based sex offender treatment programs allow for offenders not incarcerated for sex offenses to access these services if such a need is evident? |
| 22. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are treatment refusals documented in each offender's record? |
| 23. | <input type="radio"/> | | | <input type="radio"/> | Does legislation or do other mandates require sex offenders who are placed directly on probation to participate in community-based sex offender treatment? |

Community-Based Programs

always/ typically generally never/
yes not no

24. Does legislation or do other mandates require sex offenders under supervision post-release from prison to participate in community-based sex offender treatment?
25. Is sex offender treatment available in the community?
26. Are sex offenders who are placed directly on probation able to access community-based sex offender treatment immediately?
27. Are sex offenders who are released from prison able to access community-based sex offender treatment immediately?
28. Do standards or guidelines outline the ways in which community-based sex offender treatment should be delivered?
29. Do community-based and prison-based sex offender treatment programs use the same model of treatment (to promote continuity of care)?
30. Do community-based treatment providers limit their scope of services only to those clients whom they are qualified to treat?
31. Can non justice-involved individuals access community-based sex offender treatment, if needed?
32. Do community-based sex offender treatment providers demonstrate a commitment to collaborate with supervision officers, family therapists, child welfare professionals, and others to:
- Share assessment information?*
- Discuss levels of risk and needs?*
- Review treatment progress and compliance with treatment and supervision expectations?*
- Coordinate day-to-day case management efforts?*

► Questions: Juvenile Sex Offenders

Availability, Capacity, and Accessibility

Continuum of Care

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|---|
| 33. | <input type="radio"/> | | | <input type="radio"/> | Do policies or procedures require juveniles to receive treatment in the least restrictive setting allowable based on assessed level of risk? |
| 34. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | In practice , are juvenile sex offenders treated in the least restrictive setting allowable based on assessed level of risk? |
| 35. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Does a range of treatment programming exist for juvenile sex offenders, from community-based options to services in residential and juvenile correctional facilities? |
| 36. | | | | | Are sentencing/placement decisions for juvenile sex offenders informed by:
<input type="radio"/> <i>Pre-disposition reports?</i>
<input type="radio"/> <i>Psychosexual evaluations?</i>
<input type="radio"/> <i>Research-supported, juvenile sex offender-specific risk assessment tools?</i> |
| 37. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are sentencing/placement decisions for juvenile sex offenders informed by the assessed risk level (e.g., secure residential or juvenile correctional facilities for higher risk youth, community-based options for those who are lower risk)? |
| 38. | <input type="radio"/> | | | <input type="radio"/> | Are policies or procedures in place that afford juvenile justice or youth corrections agencies the latitude to make well-informed adjustments to the level of care based on significant changes (e.g., increases or decreases) in risk and need? |

Facility-Based Treatment for Juveniles

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|---|
| 39. | <input type="radio"/> | | | <input type="radio"/> | Does legislation or do other mandates require specialized, offense-specific treatment for juvenile sex offenders who are in the custody of juvenile justice agencies? |
| 40. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is specialized sex offender treatment for juveniles available within juvenile correctional facilities? |

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|---|
| 41. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are juvenile sex offenders able to access sex offender treatment within residential or juvenile correctional facilities in a timely manner? |
| 42. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is the treatment capacity in juvenile facilities sufficient to accommodate the number of juvenile sex offenders in need of those services? |
| 43. | <input type="radio"/> | | | <input type="radio"/> | Do standards or guidelines outline the ways in which sex offender treatment in residential or juvenile correctional facilities will be delivered to juveniles? |
| 44. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is there a range of sex offender treatment services available in juvenile correctional facilities (e.g., psychoeducational services, intensive programming)? |
| 45. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do private residential treatment centers provide specialized sex offender treatment to juveniles? |
| 46. | | | | | Do policies or procedures require consideration of the following factors when making facility placement decisions for juvenile sex offenders: |
| | <input type="radio"/> | | | <input type="radio"/> | <i>Least restrictive alternative?</i> |
| | <input type="radio"/> | | | <input type="radio"/> | <i>Proximity to home and/or community?</i> |
| | <input type="radio"/> | | | <input type="radio"/> | <i>Caregiver capacity and involvement?</i> |
| | <input type="radio"/> | | | <input type="radio"/> | <i>Access to victims?</i> |
| | <input type="radio"/> | | | <input type="radio"/> | <i>Risk and needs of the juvenile?</i> |
| 47. | | | | | In practice , are the following factors considered when making facility placement decisions for juvenile sex offenders: |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Least restrictive alternative?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Proximity to home and/or community?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Caregiver capacity and involvement?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Access to victims?</i> |
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <i>Risk and needs of the juvenile?</i> |
| 48. | <input type="radio"/> | | | <input type="radio"/> | Do policies or procedures require the establishment of specific, measurable, risk management-related treatment goals for each juvenile sex offender that will allow for the safe transition to less restrictive settings (including the community) to receive continuing services? |

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|--|
| 49. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | In practice , are juvenile sex offenders transferred in a timely manner to less restrictive alternatives when they no longer require the current level of structure or care? |
| 50. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Can juveniles who are placed in residential treatment centers or juvenile correctional facilities for a non-sex offense access sex offender treatment if that need is subsequently identified? |
| 51. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are treatment refusals documented in the juveniles' records? |

Community-Based Programs for Juvenile Sex Offenders

- | | <i>always/
yes</i> | <i>typically</i> | <i>generally
not</i> | <i>never/
no</i> | |
|-----|------------------------|-----------------------|--------------------------|-----------------------|---|
| 52. | <input type="radio"/> | | | <input type="radio"/> | Does legislation or do other mandates require juvenile sex offenders who are placed directly on probation to participate in community-based sex offender treatment? |
| 53. | <input type="radio"/> | | | <input type="radio"/> | Does legislation or do other mandates require juvenile sex offenders under supervision post-release from a facility to participate in community-based sex offender treatment? |
| 54. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Is juvenile sex offender treatment available in the community? |
| 55. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are juvenile sex offenders who are placed directly on probation able to access community-based sex offender treatment immediately? |
| 56. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are juvenile sex offenders who are released from facilities able to access community-based sex offender treatment immediately? |
| 57. | <input type="radio"/> | | | <input type="radio"/> | Do standards or guidelines outline the ways in which community-based treatment for juvenile sex offenders should be delivered? |
| 58. | <input type="radio"/> | | | <input type="radio"/> | Do community-based and facility-based juvenile sex offender treatment programs use the same model of treatment (to promote continuity of care)? |
| 59. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Are the parents or caregivers of juvenile sex offenders expected to be actively involved in the community-based treatment process? |
| 60. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Do community-based providers limit their scope of services only to those juveniles whom they are qualified to treat? |
| 61. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Can non juvenile justice-involved youth access community-based sex offender treatment if such a need is identified? |

always/ typically generally never/
yes not no

62.

Do sex offender treatment providers who work with juveniles demonstrate a commitment to collaborate with case managers, supervision officers, family therapists, child welfare professionals, and others to:

- Share assessment information?*
- Discuss levels of risk and needs?*
- Review treatment progress and compliance with treatment and supervision expectations?*
- Coordinate day-to-day case management efforts?*