SEX OFFENDER MANAGEMENT BOARD
JUVENILE STANDARDS AND GUIDELINES

Standards and Guidelines for Management of Juvenile Sex Offenders that are placed on Juvenile Probation and/or Aftercare

When a Youth has been adjudicated delinquent of a sexual offense as outlined in 11 Del C 4121, there shall be an exchange of information to promote effective re-entry.
When available the following information shall be included:

- Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) and/or the Juvenile Sex Offender Assessment Protocol II (J-SOAP II)
- Mental Health diagnosis, psychological reports, or testing results
- Major medical diagnosis
- Current Medication
- Information related to cognitive limitations
- Substance Abuse History
- Verified history of substance abuse treatment
- Verified history of sex offender treatment
- Discharge planning to include housing needs
- Relapse prevention plan and safety plan

I. Any Youth adjudicated delinquent of a sex offense that has been placed on Juvenile Probation or Aftercare shall be managed by a Multi-Disciplinary Team (MDT).

The purpose of the team is to staff cases, share information, and make informed decisions related to risk assessment, treatment, behavioral monitoring, and management of each offender.

Team members should consider the priorities of community safety and risk management when making decisions.

Supervision and behavioral monitoring is a joint, cooperative responsibility between the supervising officer, treatment provider, client and family, educational program, other community partners involved, and/or other Departmental Divisions.

The team is case specific and should be flexible enough to include other professionals as needed to manage and treat that offender. At a minimum each team should include: The supervising officer, the treatment provider, and DSCYF Divisional representatives as appropriate. Additional members of the team should include, but is not limited to the following: the client and family as appropriate, school representative(s), family supports, and community supports.

The team is coordinated by the supervising officer. Continuous sharing of information is expected of all team members on a monthly basis.

The team will discuss and approve appropriate safety plans for the sex offender (referred to as the Youth from this point for forward) in his/her educational setting, home, community, or other activities. The plan approved by the MDT will be signed by all

members of the team to include but not be limited to the client, family, supervising agency, treatment provider, or any other relevant party to the case and plan.

II. Responsibilities of the Supervising Officer within the Team:

The supervising officer is responsible for referring the Youth for evaluation and treatment to a SOMB approved treatment provider.

The supervising officer is responsible for presenting the appropriate releases of information to the sex offender for signature.

The supervising officer shall develop a supervision plan and contact standards based on a comprehensive evaluation that is to include, but not be limited to, a SOMB approved risk assessment of each sex offender, presenting risk factors, the offender's progress in treatment, compliance with probation conditions, and the sex offender's needs. Contact standards are fluid and will change based upon the level of risk the client presents.

The supervising officer may request early termination of supervision for a Youth when the MDT recommends such and all conditions have been completed to include but not be limited to, completion of treatment, compliance with conditions of supervision, and compliance with approved safety plans.

The supervising officer shall notify Youth who have been adjudicated delinquent of a sexual offense of his/her responsibility to comply with sex offender registration and registration verification requirement, in compliance with Title 11 4120 and 4121 and in accordance with the Family Court order. The officer shall document the Youth's compliance with sex offender registration statutes in each Youth's DYRS case file.

The supervising officer/agency should impose or request criminal sanctions for offender's unsatisfactory compliance with sex offender treatment up to and including a Violation of Probation. The determination of what level of intervention imposed will be made considering compliance issues, family support, Tier Level, risk level, and/or any other factors that are relevant to the safety of the community and progress of the client. These decisions will be discussed by the MDT.

The supervising agency shall require Youth who have been adjudicated delinquent of a sexual offense, who are transferred from other states through an Interstate Compact Agreement, to agree in advance to participate in offense specific treatment and specialized conditions of supervision contained in these standards.

The supervising officer shall not allow a Youth who has been adjudicated delinquent of a sexual offense, who has been unsuccessfully discharged from a treatment program to enter another program, unless approved by the MDT.

Officers assessing or supervising Youth who have been adjudicated delinquent of a sexual offense and their respective Supervisors are expected to successfully complete training programs specific to juvenile sex offenders. Such training shall include, but shall not be limited to information on:

- Prevalence of sexual assault
- Offender characteristics
- Assessment/evaluation of sex offenders
- Current research
- Community management of sex offenders
- Interviewing skills
- Victim issues
- Sex offender treatment
- Choosing evaluators and treatment providers
- Relapse prevention
- Determining progress
- Offender denial
- Special populations of sex offenders
- Cultural and ethnic awareness
  Juveniles presenting at-risk behaviors for sexually acting out who have not been adjudicated delinquent of a sex offense.

Officers and Supervisor who are supervising sex offenders shall obtain continuing education/training specific to sex offenders.

III. Responsibilities of the Treatment Provider within the Team

A treatment provider shall establish a cooperative professional relationship with the supervising officer and MDT team members.

A provider shall immediately report to the supervising officer all violations of the treatment plan, safety plan or specific conditions of probation and/or aftercare.

A provider shall immediately report to the supervising officer evidence or likelihood of an offender's change of risk of re-offending so that behavioral monitoring activities may be adjusted accordingly.

A provider shall report to the supervising officer any reduction in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in a Youth's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual basis by the MDT.

The treatment provider shall submit written reports to the supervising officer quarterly and upon request documenting the Youth's attendance, participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress.

The treatment provider shall complete ongoing informal risk assessment at every session or contact with the Youth. Any changes in risk level shall be provided to the supervising officer immediately.

The treatment provider shall complete a formal risk assessment at least quarterly that is approved by SOMB and indicated in this document as the ERASOR and/or J-SOAP. The formal written results of this assessment shall be provided to the supervising officer.

The treatment provider shall be willing to testify in court and furnish any written documents necessary for the legal proceedings.

A provider shall actively communicate with the supervising officer, victim therapist, custodial parent or guardian, court officials and any other MDT participants about specific plans for family reunification or other planned placement change.

IV. Responsibility of the Parent/Guardian within the Team:

The parent/guardian of a sex offender is expected to be an active participant in the MDT.

The parent/guardian will present any information to the Multi-Disciplinary Team about changes in the client's behavior and/or any other information that could impact the level of risk the Youth is presenting.

The parent/guardian will appropriately monitor the Youth's use of electronics to include but not be limited to computers, internet, cell phones, game consoles, music, or other electronical devices deemed appropriate. The parent/guardian will immediately notify the Supervising Officer and/or MDT of any sexually inappropriate use.

The parent/guardian will attend and complete a parenting class to assist with the guidelines and issues that come with having a sex offender reside in their home.

The parent/guardian will actively participate in the development of an appropriate safety plan for the home and community supervision with the MDT. Once the safety plan is agreed upon by the MDT, the parent/guardian will implement the plan, monitor the plan and its appropriateness, and report any variances or violations, as well as any increased risk behaviors to the Supervising Officer and MDT.

V. Responsibility to the School or Educational Program within the Team:

The District Administrator and/or his/her designee will be an active member of the Multi-Disciplinary Team.

The District Administrator and/or his/her designee will participate in the development of the educational safety plan centered on the school and/or school extra-curricular activities. The educational safety plan will consider the safety of peers and the risk to potential victims, as well as the needs of the Youth. This individual(s) will monitor the

safety plan for the educational setting. The District Administrator and/or his/her designee will report any variances or violations of the safety plan, as well as any increased risk behaviors, to the Supervising Officer and MDT.

The District Administrator and/or his/her designee will ensure that any and/or all accommodations needed to comply with the agreed upon safety plan developed by the MDT, are implemented in the educational setting or school extra-curricular activities.

The District Administrator and/or his/her designee will immediately notify the Supervising Officer and MDT if there are any perceived or necessary changes to the educational safety plan.

The District Administrator and/or his/her designee will, in collaboration with the MDT, determine the most appropriate educational setting for the Youth. This determination will consider, but is not limited to, the victim, risk to potential victims, ability to implement an appropriate safety plan, ability to effectively monitor the implemented safety plan, and the needs of the Youth.

VI. Conditions of Community Supervision for Youth Adjudicated Delinquent of a Sexual Offense that are Placed on Juvenile Probation and/or Aftercare.

The Youth will report to his/her Probation/ Aftercare Officer at the time and place directed.

The Youth will report any change in his/her address or telephone number immediately to their Probation/Aftercare Officer and the Delaware State Police as required for his/her designated Tier level.

The Youth will comply with his/her registration requirements as determined by the Tier Level he/she has been assigned to by the Family Court of Delaware. If he/she committed a sexual offense in another state, Delaware's Attorney General will review the charges and determine a Tier level in which the individual will be responsible to comply with the requirements of that designated Tier level.

The Youth will attend an educational/vocational program approved by his/her Probation/Aftercare Officer and MDT if applicable.

The Youth will have the permission of his/her Probation Officer, in consultation with the Multi-disciplinary team for any over night visits. Over night visits may only be approved after the development of a safety plan.

The Youth will have the permission of his/her Probation/Aftercare Officer, in consultation with the MDT if applicable, to be away from his/her home for more than 72 hours. Over night visits may only be approved after the development of a safety plan.

The Youth will obtain a Travel Permit signed prior to leaving the State of Delaware that has been approved by the MDT.

The Youth will immediately inform his/her Probation/Aftercare Officer of any contact with any Law Enforcement Agency. As a probationer, being charged with a new offense may result in action against you.

The Youth will successfully complete counseling as ordered by the Family Court of Delaware, your Probation/Aftercare Officer, or Child Mental Health. The Youth will remain with the approved service until successful completion of counseling. If a change is requested by the client or family, they will obtain approval from their Probation/Aftercare Officer and/or Multi-disciplinary team before changing services.

The Youth will undergo random urine screens. Any refusal to submit to a random urine screen will automatically be considered a positive test and he/she may be referred for a substance abuse evaluation.

The Youth will abide by any no contact orders on his/her Court Order or implemented by his/her Probation/Aftercare Officer.

The Youth will have no contact with his/her victim. This includes but is not limited to face to face contact, letters, electronic communication, telephone, or through another person. If the victim is in the home, consideration of the victim will be utilized to determine if the Youth is able to return to the home where the victim is residing.

If the Youth has contact with anyone that he/she has been restricted from having contact with, even accidental, it is his/her responsibility to remove him or herself from that situation in a responsible manner.

The Youth will not enter into a position of trust or authority with any child or potential victim. This includes babysitting or watching any children or adolescents, employment and/or volunteering. There are no exceptions for babysitting or watching children or adolescents. For employment and volunteering, he/she will obtain the permission of their Probation/Aftercare Officer in consultation with the MDT, so that a safety plan can be developed before starting employment or volunteering.

The Youth will not have possession of any weapon.

The Youth will not be in possession of or view pornographic materials, X-rated or sexually arousing materials and he/she will not go to or loiter in areas where pornographic materials are sold, rented, or viewed.

The Youth will sign waivers of confidentiality so that his/her Probation/Aftercare Officer may be able to communicate with other professionals involved in his/her supervision and treatment. This will include release of information for the victim's therapist.

The Youth will obey a curfew set by Family Court, his/her Probation/Aftercare Officer and/or parents.

The Youth will pay all court costs and fines if applicable as ordered by the Family Court of Delaware.

The Youth will complete all other special conditions as court ordered or imposed by his/her Probation/Aftercare worker.

VII. BEHAVIORAL MONITORING OF SEX OFFENDERS IN THE COMMUNITY

The supervising officer must be aware of the offender's potential to re-victimize and use multiple methods of behavioral monitoring to ensure public safety.

- Behavioral Monitoring Activities include, but are not limited to:
- Interview Techniques
- Referral to outside agencies to address criminogenic needs
- Regular contact in both the office and the field
- Third party corroboration of information
- Follow up on third party information
- Monitoring compliance with court ordered, probation, and sex offender conditions
- Reinforce treatment concepts
- Communicate and educate those significant individuals in the offender's life on potential risk and appropriate support
- Limit behavior related to sexual re-offense
- On-going assessment of residence, employment, and social environments to
- ensure sufficient protection exists against potential re-offense
- Electronic Monitoring/GPS

2.0 **Assessment and Ongoing Assessment of Juveniles who have been Adjudicated Delinquent of a Sex Crime**

2.1 The evaluation of juveniles who have been adjudicated delinquent of a sex crime (hereafter referred to as "juvenile[s]") shall be comprehensive. Recommendations for intervention shall be included in the summary and the evaluation shall be provided in written form to the referring agent. The evaluation of these juveniles has the following purposes:

- To assess overall static and dynamic risk factors for future sexual re-offense
- To assess safety for the victim(s) or potential victims
- To provide written clinical assessment of a juvenile's strengths, risks and deficits
- To identify and document treatment and developmental needs
- To determine amenability for treatment
- To identify individual differences and potential barriers to treatment;
- To make recommendations for the management and supervision of the juvenile and ensure safety for victim(s) and potential victims
- To provide recommendations that identify the type and intensity of community based treatment or the need for more restrictive setting

Comprehensive evaluation and assessment is an on-going process. Client status and needs change over time; progress in treatment and level of risk are not constant over time and may not be directly correlated; risk and protective factors must be assessed on an on-going basis as part of regular review of the treatment plan—see Section 3.0 Standards of Practice for Treatment Providers.

2.2 Recommendations regarding intervention shall be based on a juvenile's level of risk and needs rather than on resources currently or locally available. When resources are less than optimal, this information shall be documented and an alternative recommendation must be made.

Evaluators and professionals providing ongoing assessments shall comply with the following standards for each assessment that is completed. All assessments will be completed by a clinician who meets the criteria of the SOMB Provider List.

- Presentence and post-adjudication: (Dangerousness, risk, treatment needs) An assessment containing the elements set forth in these Standards must be done prior to sentencing to determine the juvenile's level of danger and risk to victim/self/community, appropriate placement needs, level of care and treatment needs. The multidisciplinary team is expected to have a collaborative relationship at this point and to fulfill the specific roles relative to agency involvement.
- Ongoing needs assessment**:** (Treatment planning, progress review and continuation of services—treatment or supervision) The juvenile's progress in treatment and adherence to conditions of supervision must be assessed on an ongoing basis. Regular treatment reviews will assess for progress and any new risks or issues that have emerged and the treatment plan will be amended accordingly to account for new information. Level of risk must be assessed at transition points (i.e. sentencing, admission to treatment, prior to designation of family/community visits, prior to discharge, transitions to school, home or

community, at change in level of treatment or care) and will include level of functioning, treatment and supervision needs, strengths/protective factors, need for monitoring and need for follow up services. Measurements and testing instruments will be utilized as clinically indicated and outlined in the Standards.

- Release/termination**:** (Community safety, reduced risk and successful application of treatment methods) Prior to discharge from treatment, a final assessment is necessary. The final assessment shall make recommendations for follow-up and aftercare services. Recommendations will include continued treatment needs, support network, supervision requirements, safety plan (especially if returning home with victim), placement (if family is not an option) and any other services or resources necessary to support the youth in maintaining treatment gains.

- Follow-up monitoring**:** (Continued monitoring in the community) The Division of Youth Rehabilitative Services, multidisciplinary team and/or other supervising agents must continue to monitor the juvenile's post-treatment release in compliance with the court ordered requirements. **[**See DYRS ISB unit policy and procedures for more detail]

2.3 The evaluation and subsequent assessments shall be sensitive to the rights and needs of the victim.

- All evaluations and assessments will include review of the victim's or victim's family's statement at pre-trial investigation or more direct gathering of information in order to thoroughly incorporate the risks and concerns presenting in the case. A comprehensive evaluation requires that the evaluator have access to the police report, Affidavit of Probable Cause, Child Advocacy Center interview, copy of the court order for the evaluation, and all court dispositions. The specifics of the juvenile's charge, specific behavior and impact on the victim should be reviewed at all points of treatment, planning and disposition/transition points in addressing the management and treatment of the juvenile.
- The evaluation will include the review of the victimization of the juvenile or any information that may indicate a history of victimization of the juvenile in order to recommend treatment and services that best address these issues. These issues will be a critical element of treatment as well as discharge/release planning in order to ensure that the juvenile returns to a safe environment.

2.4 The evaluator shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the evaluation. The evaluator will meet the requirements identified in the Standards and will select evaluation procedures and instruments relevant to the individual circumstances of the case and commensurate with their level of training, expertise and best practices.

2.5 Evaluation methodologies must include a combination of clinical procedures, screening level testing, self report or observational measurements, advanced psychometric measurements, specialized testing and measurements. Due to the complexity of evaluating juveniles who commit sexual offenses, methodologies should be guided by the use of instruments that have

specific relevance to the evaluation of juveniles and the use of instruments with demonstrated reliability and validity which are supported by research in the mental health and juvenile problem sexual behavior treatment fields.

Each stage of assessment shall address strengths, risks and deficits in the following areas:

- Cognitive and emotional functioning
- Personality, mental disorders and mental health
- Social/developmental history
- Developmental competence
- Current individual functioning
- Current family functioning
- Trauma history and exposure
- Sexual development and knowledge
- Delinquency and conduct/behavioral issues
- Assessment of risk—community risk and protective factors
- Awareness of victim impact—understanding and insight into behavior
- External relapse prevention systems including informed supervision
- Amenability to treatment

Evaluation methods may include the use of clinical procedures [including clinical interview], screening level tests, observational data, advanced psychometric measurements and special testing measures. In keeping with best practice, evaluation reports more than 6 months old should be regarded with caution.

2.6 Evaluation methodologies will include:

- Examination of juvenile justice information and/or DSCYF reports, police reports and prior offense history;
- Details of the offense/factual basis and any victim statements including a description of harm done to the victim;
- Examination of collateral information, including information regarding the juvenile's history of sexually inappropriate behavior including adjudication on sexual offenses;
- A sex offense specific risk assessment protocol: ERASOR, J-SOAP-II;
- Adaptive cognitive testing if indicated;
- Use of multiple assessment instruments and techniques. A list of commonly recognized/validated clinical assessment instruments are listed in the Appendix;
- Structured clinical interviews including a sexual history;
- Integration of information from collateral sources; and
- Standardized psychological testing if clinically indicated.

2.7 Assessment by the Division of Family Services [DFS]: The intake worker will assess whether the investigation report:

- Involves child[ren] between the ages of birth to 18
- Alleges child abuse, neglect, or dependency as defined in statute or risk thereof
- Alleges intra-familial or institutional abuse

- Further specified in DFS policy referenced below:
    - Investigation of abuse, neglect or dependency occurring in the past (more than one year) will be determined on a case by case basis and in consideration of the current safety of the child and potential risk to the child or other children in the home. (The Division will not accept reports for investigation alleging abuse or neglect of an adult while they were a child, age 18 or younger, unless the adult is presently residing in a foster care or residential care facility).
    - The information involves intra-familial or institutional abuse. Intra-familial is guided by the definition of relative in 10 Del.C. §901
    - The Division shall accept a report when the report describes child abuse, neglect or dependency by a sibling when the information received clearly indicates a sibling may have been a person left with care, custody or control of the victim.
    - The Division must conduct an investigation for all reports, which if true, would constitute violations against a child by a person responsible for their care, custody or control. Division staff shall also contact the appropriate law enforcement agency upon receipt of such report. Whenever it appears that an act against a child may result in criminal charges against the parent/caretaker (or person in control), the Division will report to the appropriate police agency.
    - The Division is responsible for the investigation of allegations of physical and sexual abuse in out-of-home settings. These settings include transitional living programs, residential child care facilities (group homes), foster homes, licensed child day care facilities, shelter, correctional and detention facilities, day treatment programs, all facilities at which a reported incident involves child[ren] in the custody of DSCYF, and all facilities operated by DSCYF. License exempt childcare facilities (schools, hospitals or church operated babysitting/Sunday schools) are not included and those reporters should be referred to the police.
    - Child Sexual Abuse: The Division accepts and investigates reports alleging intra-familial child sexual abuse, including older siblings/other relatives. The report will also be accepted when sexual abuse is alleged for other persons living in the household. The Division screens reports to determine if a person meets the definition of a sexual predator, i.e. an adult 19 years older with a victim less than 14 years of age or an adult 10 years older than the victim, when the victim is less than 16 years of age. For reports meeting the definition of sexual predator, the Division has additional responsibilities, including tracking numbers and reporting to the appropriate police agency. The Division accepts reports of extra-familial child sexual abuse only to ensure that the appropriate police agency is notified.

2.8 The evaluator will obtain informed consent from parent or guardians and the juvenile. This informed consent will include: communication regarding the evaluator's adherence to the mandatory reporting law, the relationship between the evaluator and the court, evaluation methods, how the information may be used and to whom it will be released and the juvenile's

right to be fully informed about the evaluation procedures. Results of the evaluation will be reviewed with the juvenile and parent/guardian as agency policy prescribes. Sexual offenders are obligated to consent to an evaluation. Should the youth or caregiver not be willing to consent, the recourse will be through the juvenile justice system and the referring court.

3.0 Standards of Practice for Treatment Providers

Treatment for juveniles who have been adjudicated delinquent on a sexual offense shall be provided by treatment providers or SOMB provider list treatment professionals meeting the qualifications described in Section 4 of these standards.

3.1 Treatment providers who treating youth adjudicated delinquent on a sexual offense, whether receiving treatment in an in state agency/program or an out of state program shall provide sexual offense specific treatment and care as described in these Standards and Guidelines. This treatment shall be provided through three modalities: individual, family and group. The therapist or treatment team designee will participate in the Multidisciplinary Team and implement treatment in the context of the MDT plan. Juveniles receiving this treatment will be held accountable for participation in treatment and will be supervised by caregivers or providers in a manner congruent with these Standards and Guidelines.

Traditional psychotherapy is not sufficient for treatment of youth adjudicated delinquent on sexual offense(s).

3.2 Providers, in concert with the multidisciplinary team, shall develop a written treatment plan based on the individualized evaluation and assessment of the juvenile, family dynamics and recovery environment, and with adherence to applicable Department contracting requirements.

Treatment Plans

A. Sex offense specific treatment shall be designed to address strengths, risks and deficits and all areas of need identified by the evaluation [described in section 2.0] and shall:
    1. Provide for the protection of past and potential victims, and protect victims from unsafe or unwanted contact with the juvenile.
    2. Include treatment goals and interventions that are individualized to improve family functioning and enhance the abilities of support systems to respond to the juveniles' recovery needs and concerns.
    3. Favor consistency in caregiver relationships.
    4. Implement interventions that address the juvenile's need for pro-social peer relationships, activities and success in educational/vocational settings.
    5. Describe participation and supervision expectations for the juvenile, the family/caregivers, educators and support systems which exist.
    6. Develop detailed, long-term relapse prevention and aftercare plans to address risks and deficits that remain unchanged [e.g. cognitive deficits, developmental disabilities, medical/physical issues, etc.].
    7. Describe relevant and measurable outcomes that will be the basis of determining successful completion of treatment.

B. The treatment plan shall be reviewed at a minimum of every three months and at each transition point. Revisions shall be made as needed.

C. Sex offense specific treatment methods and intervention strategies shall be based on an individual treatment plan that has been developed by the multidisciplinary team, response to the individual evaluation and ongoing assessments. A combination of individual, group and family therapy shall be used unless contraindicated. When the multidisciplinary team determines a specific type of intervention is contraindicated, the issue[s] shall be documented and alternative interventions shall be listed. If and when the contraindications change and the modality is viable, the treatment plan shall be amended accordingly.

D. The treatment process shall include holistic preventative interventions as well as treatment interventions that focus on increased self control and efficacy, as well as more dynamic issues. In addition, it shall address the tem stages of treatment:

1. Stabilization and Containment: primary focus is on emotional and behavioral stability and the development of self regulation
2. Engagement and Attachment: involving the ability of juveniles to form attachments with the therapist and the development of the therapeutic alliance.
3. Acceptance of Responsibility: juveniles must move, at least in a rudimentary way, through denial and begin to acknowledge and accept responsibility for sexually abusive behavior.
4. Learning New Language and Ideas: focus on helping juveniles to recognize how ideas, attitudes and beliefs affect and influence sexually abusive behavior and other anti-social and self defeating behaviors.
5. Developing Awareness: helping juveniles to become more aware of themselves, their motivations and their influences, the needs of others and their impact on others.
6. Applying New Ideas to Behavior: juveniles demonstrate their ability to retain what they have learned and demonstrate changes in their behaviors and social interactions.
7. Commitment to Change: juveniles, in preparation for discharge, must recognize the necessity of change and demonstrate their motivation and ability to sustain behavior change.
8. Development and Application of a Relapse Prevention Plan: development of a refined and active behavioral safety plan. This stage may include victim clarification and other goals related to return to family (or to the community) if indicated by the Multidisciplinary Team.
9. Discharge from Active Treatment: at the end of a treatment episode or at a point of transition in service, it is critical that the Multidisciplinary Team is involved in the continuing care planning process and committed to the plan.
10. Maintaining a Safe Lifestyle: A juvenile in a post treatment stage, which includes an identified support network, behavioral monitoring and supervision, on-going counseling, and other forms of interventions designed to ensure a healthy and safe lifestyle.

Treatment Modalities

A. Group therapy provides psycho-education, promotes development of pro-social skills, provides positive peer support and/or is used for group processing of attitudes, beliefs, thoughts and/or behaviors. Therapist/Client ratios shall be no less than 1:8 or 2:12
   1. Treatment providers must monitor and control groups to minimize exposure to deviance, deviant peer modeling and to provide for the safety of all group members.
   2. Co-therapy is always recommended--male and female co-therapists are preferred

B. Individual therapy is used to address mental health issues and/or to support the juvenile in addressing issues in group, family or milieu therapy. Therapist/ Client ratio shall be no less than 1:1.

C. Family therapy addresses family systems issues and dynamics. This model shall address, at minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification and aftercare plans. Therapist/ Client ratios shall be no less than 1:8 or 1:12

D. Multi-family groups provide education group process and/or support for the parent and/or sibling[s] of the juvenile. Inclusion of the juvenile is optional. The treatment provider monitors and supervises confidentiality. Therapist/Client ratios shall be no less than 1:8; 2:15; 3:18; 4:24]

E. Other treatment settings:

   1. Clarification sessions shall occur as prescribed in Section 5.0 of these Standards.
   2. Dyadic therapy is used when approved by the multidisciplinary team.
   3. Psycho-education is used for teaching definitions, concepts and skills Therapist/Client ratios shall be no less than 1:12; 2:20]
   4. Milieu therapy is used to promote growth, development and relationship skills; to practice pro-social life skills; and to supervise, observe and intervene in the daily functioning of the juvenile. A combination of male and female role models are preferred in staffing milieus [Provider: Client ratios shall not be less than the following: 10-12 year olds, 1:8; 13 and older 1:10].
   5. Self-help or time limited treatments are used as adjuncts to enhance goal oriented treatment. Adjunct treatments must be complementary to sex offense specific treatment.

Referrals and Compliance with SOMB Standards and Guidelines

A. The Family Court, DYRS, and/or the Multidisciplinary Team shall make referrals to sex offense specific treatment as indicated by an evaluation as outlined in Section 2.

B. Therapists chosen by the multidisciplinary team to provide sex offense specific services will be chosen with all reasonable efforts to engage a therapist that is on the Sex Offender Management Board provider list. If this is not possible, the therapist must have a level of experience and knowledge of juvenile sexual development and juvenile sex offense specific dynamics (as determined by the multidisciplinary team) to adequately provide the service (See criteria for inclusion on the SOMB provider list).

C. It is expected that all therapists and programs providing sex offender specific treatment come into compliance with SOMB Standards and Guidelines for Juvenile Assessment, Treatment and Supervision. When a treatment provider is unable to adhere to these standards and guidelines, the entity shall provide to the MDT, and if unable to resolve at that level, SOMB or its delegated committee, documentation of the juvenile's needs, the circumstances that prevent adherence, and an alternative solution or referral.

3.3 Content and Outcomes of Treatment

Treatment Content shall include but is not limited to:

A. Awareness of victim impact without objectification or stereotyping of the victim; recognition of harm to the victim; recognition of harm to victim; impact of behavior on victim(s), families, community and self; recognition of victim(s) experience through exercises like perspective taking and role play; preparation to victims (including the community). For details see Section 2;
B. Ability to define abusive behaviors; abuse of self, others, property, and/or physical, sexual and verbal abuse;
C. Accept responsibility for the behaviors, past and present without minimization or externalization of responsibility or blame;
D. Identification of patterns of thoughts, feelings and behaviors associated with the behaviors;
E. Identification of cognitions supportive of anti-social or violence themed attitudes;
F. The role of sexual arousal in sexually inappropriate and sexual offending or abusive behaviors; definition of non-offensive and non-abusive sexual fantasy; reduction and disruption of deviant sexual thoughts and arousal, when indicated;
G. Disinhibiting influences such as substance abuse, mental illness, stress, impulsivity and peer influences;
H. Anger management, conflict resolution, problem solving, stress management, frustration tolerance, delayed gratification, cooperation, negotiation and compromise, coping and social skills;
I. Recognition of static & dynamic risk factors;
J. Skills for safety planning, risk management, relapse prevention strategies;
K. Identification of physical health and safety needs – STD and HIV included;
L. Accurate information about human sexuality; positive sexual identity;
M. Understanding developmental deficits, delays skills for successful functioning;

N. Relationship skills –e.g. boundaries, trust, open/honest communication of needs, respect others needs and wants, etc;
O. Internal locus of control – i.e. internal sense of mastery, behavioral control and competency;
P. Family dysfunction and/or deviance including intimacy and boundaries, attachment disorders, role reversal, sibling relationships, substance abuse, criminality and psychiatric illness. Responsibility of therapist and others on the multidisciplinary team for mandatory reporting of harm;
Q. Values recognition of how attitudes of family, peer group, community and cultural influence tolerance of sexually abusive/offending behavior;
R. Experiences of victimization, trauma, maltreatment, loss, abandonment, neglect, and exposure to violence in the home or community;
S. Legal parameters and consequences relevant to sexual offending;
T. Diagnostic assessment, stabilization, pharmacological treatments and management of concurrent psychiatric or addictive disorders.

Treatment Outcomes shall be maximized by the treatment intervention and shall be measurable and relevant to the dynamic functioning of the juvenile in the present and future by:

A. Decreasing the risk of sexual and non-sexual deviance, dysfunction and offending behavior.
B. Improving overall health, strengths, skills and resources to successful functioning and productive adulthood.
C. All outcomes shall be defined and measured in behavioral terms in regards to frequency, severity, transparency or other observable, measurable means.
D. Outcomes relevant to decreased risk include (but are not limited to):
    1. Juvenile consistently defines and identifies all types of abuse (others, self and property) as well as appropriated and respectful boundaries.
    2. Juvenile acknowledges risk and uses foresight, personal strategies and safety planning to manage risk.
    3. Juvenile consistently recognizes and interrupts patterns of thought and/or behavior associated with his/her abusive behavior.
    4. Juvenile consistently demonstrates emotional recognition/regulation, expression and appropriate empathic response to self and others.
    5. Juvenile demonstrates functional coping patterns when stressed.
    6. Juvenile take responsibility of own behavior and does not blame on others.
    7. Juvenile demonstrates the ability to manage frustration and unfavorable events, anger management and self protection skills.
    8. Juvenile manages or rejects abusive thoughts/fantasies – or – seeks support if s/he cannot.
E. Outcomes relevant to increased overall health include (but are not limited to):
    1. Juvenile demonstrates pro-social relationship skills and is able to establish closeness, trust and assess trust worthiness of others.
    2. Juvenile has improved positive self image and is able to be separate, independent and competent.

3. Juvenile is able to resolve conflict and make decisions that are appropriate and do not present risk of harm to others or self.
4. Juvenile able to relax, play and is able to celebrate positive experiences.
5. Juvenile seeks out and maintains pro-social peer relationships.
6. Juvenile ability to plan for and participate in structured pro-social activities.
7. Identified family and /or community supports for positive/pro-social behavior.
8. Juvenile has productive, pro-social goals and continues to work toward them; respects reasonable authority and limits around his pursuit of goals.
9. Juvenile is able to think and communicate clearly, honestly and effectively.
10. Juvenile is able to adapt goals and planning with in understanding of the accommodations necessary in the context of his/her offending and its consequences.

Relapse Prevention and Discharge/Aftercare Planning

The treatment provider shall continue to provide or recommend treatment at a different level of care until the juvenile has achieved the treatment goals. Planning for discharge/aftercare and development of the relapse prevention plan begins at the point of evaluation and admission to treatment program. Planning for this stage of treatment shall be done by the multidisciplinary team, and shall be developed based on the risk and the on –going needs of the juvenile. As the multidisciplinary team shall consider the remaining treatment plan goals for discharge/aftercare and relapse prevention planning. The following content areas shall be addressed:

A. Physical safety in the living environment and community;
B. Psychological safety in the living environment and in relationships;
C. Defining types of offending and abusive behavior in the living environment and community. Defining types of healthy sexual behavior and comfort with own sexuality/sexual orientation;
D. Recognition of patterns associated with abusive behaviors in daily functioning;
E. Activities which increase developmental skills and competencies;
F. Relationships which include trust, emotional expression, skills around empathy and perspective taking, communication, effective problem/conflict resolution, and respectful boundaries;
G. Exposure to male and female, adult and peer positive role models;
H. Participation in normative experiences and pro-social activities;
I. Relaxation, recreation and play;
J. Implementation and evaluation of safety planning for daily activities;
K. Development and promotion of pro-social attitudes.

3.4 Documentation of the Treatment Process

Treatment providers shall maintain client files in accordance with the professional standards of their individual disciplines, accreditation and licensing bodies. It is considered best practice to have records that are as complete as possible. The complete case record must provide information obtained in all areas of the juvenile's life that are impacted by the offense and subsequent interventions. This includes all consents and

informed consent, client rights and responsibilities, and other paperwork related to consent to treat and release of information (confidentiality/HIPAA). When indicated services are not available, it must be noted and an alternative plan delineated. All information related to planning, review, and conditions of the court shall be documented and all participants noted.

Client files shall include, but are not limited to:

A. Informed consents, releases of information, client rights and responsibilities, consent to treat and other related documentation of information management.
B. Evaluations, assessments, presentence investigations and treatment plans.
C. Documentation of MDT meetings.
D. Documentation of assignments (individual/family) and progress.
E. Critical incidents occurring during treatment.
F. Barriers to successful completion of treatment and/or lack of resources and systemic response to treatment issues.
G. Non-adherence by juvenile, family or support system.
H. Discharge criteria, relapse prevention plan and recommendations for next level of care—associated transfer and discharge paperwork.
I. Availability or ability (or lack thereof) family and/or community resources to support aftercare—and a plan to address gaps.
J. Documentation of information that would be relevant to any legal processes available to the youth re: registration, expungement, or other legal options or consequences the youth or family may have at the point of discharge.

3.5 Confidentiality

Per professional ethics, standards and guidelines, as well as federal regulations regarding health and substance abuse information management, clinicians are bound by the parameters of confidentiality regarding client information. Exceptions to these parameters are mandatory reporting of intent for self harm, abuse and Tarasoff reports of threats/intent to harm others. The Department of Services for Children, Youth and their Families, as well as the three service Divisions have policy and protocols around protection of rights to confidentiality. All providers will be held to these policies and protocols. In addition to the Department policy, HIPAA regulations outline the regulation of health information with particular attention to electronic information on clients. 42 CFR Part 2 provides specific parameters around the sharing of substance use information and client information for those persons receiving treatment for addictions. The following is required:

A. Limits of confidentiality shall be outlined specifically and clearly in the Consents to Release Information and in the Informed consent with the client's signature confirming his/her understanding of what information will be shared.
B. Adherence to DPBHS provider manual and the confidentiality standards contained in the manual
C. Clear communication, as part of the informed consent, to the requirements and conditions outlined in the court order.

D. Clear communication regarding the requirements of registration as it applies to public notification and the information that the provider is mandated to share in the context of the level of registration.
E. Appropriate documentation, editing and safeguards for clinical information in an electronic and paper client chart.

3.6 Client Rights and Responsibilities

The provider shall have written client rights and responsibilities information that shall be reviewed with the client and family at admission. These shall include but are not limited to:

A. Rights:
    1. Confidentiality
    2. Appropriate and ethical clinical services
    3. Respect
    4. Clear therapist/client relationships boundaries
    5. Active participation in the treatment planning and review process
    6. Complaint/grievance process that is reviewed with the client
    7. Clear communication around any payment or other fiscal obligations
B. Responsibilities:
    1. Schedule and attend sessions
    2. Adherence to mutually developed treatment plan and other requirements outlined in the admission process
    3. Participate in all court, MDT, school and other team meetings regarding the child/youth
    4. Respect
    5. Adhere to the boundaries of the therapist/client relationship
    6. Follow through with any specific community/court/social services processes identified

3.7 Completion or Termination of Sex Offender Specific Treatment

Completion or termination of Sex Offender specific treatment will be a determination of the treating clinician and appropriate discharge/transfer documentation and activities will be completed per above standards. The MDT shall participate in the process of determining completion of treatment, and if there are risk or safety concerns at completion of treatment, all members of the MDT shall work to develop an alternative plan. This may include alternative clinical as well as structural, environmental services—e.g. ISB unit increased supervision, less intensive treatment services, family participation in behavior or activities plan, plans for supervision at school, etc.

3.8 Phallometric Assessments and Polygraph

Decisions regarding these assessments will be made on a case by case basis. DSCYF does not use phallometric assessments, and polygraph assessments are approved with special and specific clinical and behavioral rationale. If an assessment is done, the provider will meet the standards and professional criteria outlined in the SOMB standards.

4.0 STANDARDS AND GUIDELINES FOR MULTIDISCIPLINARY TEAMS FOR THE MANAGEMENT OF JUVENILES WHO HAVE BEEN ADJUDICATED DELINQUENT OF A SEX CRIME

Once a juvenile has been adjudicated and sentenced for a sexual offense, a referral to DYRS should be made. The supervising probation officer shall convene the MDT to manage the juvenile and his/her family during the term of supervision. The supervising Probation Officer shall ensure that the treatment recommendations are implemented and that any other statutory requirements are met.

Multidisciplinary Team Functions

The purpose of the multidisciplinary team is to manage and supervise the juvenile through shared information. The individualized evaluation, information from all caregivers, and ongoing assessments will provide the basis for team decisions related to risk assessment, treatment and behavioral monitoring.

Supervision and behavioral monitoring are the collaborative and cooperative responsibilities of the multidisciplinary team.

All reasonable efforts need to be made to advise parents/guardians of the multidisciplinary team's expectations including the requirements of informed supervision. Parents/Guardians and caregivers are recognized as having an integral role in the juvenile's development and, ultimately, community-based stability.

Family involvement with the multidisciplinary team is strongly encouraged throughout the supervision and care continuum. Families provide invaluable information about the juvenile's environment and are in most cases the central support system of the juvenile. Family involvement is required in treatment per these Standards in Section 3.

I. Each multidisciplinary team shall at a minimum consist of:

A. The supervising Probation Officer
B. Parent(s)/Guardian(s)/ Caregiver(s)
C. DSCYF caseworker(s), if assigned
D. The juvenile's caregiver in any out-of-home placement
E. The treatment provider

The team may include other clinical professionals, school personnel, victims therapist, family supports, and community supports. If family re-unification is the goal and the victim is in the family, a victim advocate should be included in the MDT. If there is not a

victim advocate involved with the family, a representative from the Department of Justice can be included.

Each team is formed around a particular juvenile and is flexible enough to include any individual necessary to ensure the best approach to managing and treating the juvenile. The multidisciplinary team members perform separate and distinct functions relative to their agency affiliations. Maintaining the integrity of the team and the specified relationship with the juvenile are crucial to the success of the team. Therefore, team members shall not perform more than one role for an individual juvenile. In smaller communities professionals may work for two agencies. In these cases their primary role must be identified. The professional may act as a secondary or co-facilitator after primary role clarification is made.

II. The multidisciplinary team shall demonstrate the following operational norms:

A. There is an ongoing, completely open flow of information among the mandatory members of the team, and, as appropriate, among other members.

B. Each team member fulfills their assigned responsibilities in the management of the juvenile. When members of the multidisciplinary team wish to attend group or other treatment sessions it must be for specifically stated purposes relative to the treatment of the juvenile. Treatment providers should prepare juveniles and their parents/caregivers/guardians in advance for attendance of the multidisciplinary team member. It is understood that treatment providers may set reasonable limits on the number and timing of visits to minimize any disruption of the treatment process.

C. Team members are committed to the team approach and should resolve conflicts and differences of opinion that might make them less effective in presenting a unified response. Conflicts or alignment issues that occur may be resolved with assistance from a supervisor.

D. Because these Standards apply to adjudicated and sentenced juveniles, the final authority regarding community safety and supervision rests with the probation officer. The probation officer has final authority in all decisions regarding conditions set by the court and regarding court orders in the delinquency action.

Situations may arise, including emergencies, that require a multidisciplinary team member to make an independent decision in order to protect victims and/or community safety. Independent decisions should be the exception rather than the

rule. These decisions must be reviewed as soon as possible with the multidisciplinary team.

E. A record of all decisions made shall be entered into the case file and considered part of the complete case record. Probation officers may at times be placed in the position of taking a case back to court for a ruling on a specific issue that could not be resolved by the multidisciplinary team. The multidisciplinary team should be mindful of the level of decision-making that would require court intervention and seek remedy only after team solutions have been deemed unattainable by the team members. Probation officers are encouraged to work diligently within the framework of the multidisciplinary team before seeking action from the court.

III. The probation officer shall ensure that the juvenile and the guardian have signed informed consents to release confidential information in order to obtain all relevant information required for the evaluation, assessment, treatment and management of the juvenile. The informed consent must authorize the release of specifically documented information to and from the mandatory members of the multidisciplinary team. Such information shall include, but is not limited to:

1. Treatment plans and progress/discharge reports from current and previous treatment programs and providers
2. Medical, psychiatric and psychological reports
3. School records
4. Child abuse investigation report(s).

Relevant information may also be received from and released to professionals working with the victim(s) (if the victim/parent/guardian gives consent) of the juvenile's offense(s). The privacy associated with victims' records must be respected. Such information may be needed by the team to make decisions about contact and/or reunification, to correct empathy deficits and to resolve discrepancies in differing account of the offense and/or relationship.

The juvenile and guardian must be given the opportunity to give full, informed consent for such and advised of the consequences. In the absence of voluntary signatures, the release of records must be ordered by the court.

IV. Responsibilities of Treatment Providers

The treatment provider is a required member of the multidisciplinary team. The provider shall establish a cooperative professional relationship with the probation officer and with other relevant MDT members. The responsibilities include but may not be limited to:

A. Participating in multidisciplinary team meetings
B. Conducting treatment in compliance with these Standards.
C. Report immediately to the probation officer all violations of the provider/client contract, including those related to specific conditions of probation.
D. Reporting to the probation officer any reduction in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in a juvenile's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual case basis by the provider and the multidisciplinary team.
E. Submitting to the probation officer monthly progress reports documenting at a minimum a juvenile's attendance, participation in treatment, changes in risk factors, changes in the treatment plan, and treatment progress.
F. Furnishing, when requested by the probation officer, written information regarding the juvenile's treatment progress for a return to court. The information shall include: changes in the treatment plan; dates of attendance; treatment activities; the juvenile's relative progress and compliance in treatment; and any other material relevant to the court at hearing. The treatment provider shall be willing to testify if requested.
G. Discussing specific plans for any and all contact of the juvenile with the victim(s) and plans for clarification and family reunification with the probation officer, the victim's therapist, a representative from the Department of Justice, caseworker, custodial parent, and/or foster parent.
H. Making recommendations to the probation officer regarding selections of informed supervisors [caregivers/adults] for a juvenile's contact with children, if such contact is allowed.
I. Assessing the juvenile's ongoing level of risk to ensure containment and make recommendations for corrective or legal actions that are developmentally appropriate.
J. Making recommendations to the multidisciplinary team regarding a juvenile's level of community access with specific focus on schools, extra-curricular activities, recreation activities (including organized sports), employment or volunteer work, and access to children, siblings or potential victims.
K. Sharing case information with collateral parties as needed consistent with confidentiality policies. The provider shall advocate for developmentally appropriate evaluations, assessments, treatment and interventions.

V Responsibilities of the Department of Services for Children, Youth and their Families and Contracted Providers

A. In cases when the Division of Family Services is involved due to dependency of a youth:

1. DFS caseworker will be a member of the MDT and assist with the development of a Treatment Plan.

2. When placement becomes an issue, the DFS caseworker will convene the MDT to make recommendations for the appropriate placement. If needed, recommendations will be communicated to the Department' Placement Resource Team for placement consideration.

3. The best interests of the victim are paramount when considering out-of-home placement. Consideration should always be to maintain the victim in the home if it is safe for the victim, and to petition Family Court for custody if there are safety concerns.

4. DFS caseworker will monitor the compliance of the Family Treatment Plan by the family and report finding to the multi-disciplinary team, per confidentiality policies.

5. The DFS caseworker shall direct and educate any DFS placement resource to not allow contact between the juvenile and the victim(s) siblings, or potential victims (unless approved by the MDT) and to abide by the established safety and supervision plan established by the MDT.

B. In cases when the Division of Youth Rehabilitation Services is involved:

The Division of Youth Rehabilitation Services shall comply with Section 1.0 of these Standards. DYRS will participate with the MDT in compliance with the DYRS standards and guidelines.

C. In cases when the Division of Prevention and Behavioral Health is involved:

1. A member of the Clinical Services Management Team will be a member of the MDT and provide clinical expertise for the Treatment Plan.

2. DPBHS will coordinate needs for intensive psychological or psychiatric assessment, authorize clinically necessary treatment services for Medicaid and

uninsured youth/families in our treatment services network. This includes updates on progress, status and changes in services.

3. DPBHS will evaluate needs regarding any prevention efforts or early intervention efforts within the family and facilitate access to needed prevention/early intervention programs and interventions.

4. DPBHS will actively case manage those youth transitioning to adulthood, and when indicated make appropriate referrals for services at DSAMH.

VI Responsibilities of the Informed Supervisor and Therapeutic Care Provider

Anyone seeking to become an informed supervisor and therapeutic care provider for a juvenile who has been adjudicated of a sexual offense shall meet the following three (3) criteria in addition to any other requirements.

A. Is not currently under the jurisdiction of any court or criminal justice agency for a matter that the multidisciplinary team determines could impact his/her ability to safely serve as an informed supervisor or therapeutic care provider.

B. He/she has no prior conviction for unlawful sexual behavior, child abuse, neglect, or domestic violence.

C. If ever accused of unlawful sexual behavior, child abuse, or domestic violence, he/she presents information requested by the multidisciplinary team so that the multidisciplinary team may assess current impact on his/her ability to serve as an informed supervisor or therapeutic care provider.

Standardized training for informed supervisors and therapeutic care providers will be developed by DSCYF. Agency employees who provide informed supervision and therapeutic care will be required to complete this training.

Informed Supervisor

The primary care provider of a juvenile who has committed a sexual offense has a responsibility to provide informed supervision. Informed supervisors are defined as primary care providers, parents (if not directly involved in the treatment process), advocates, mentors, spiritual leaders, teachers, work managers, coaches and others as identified by the multidisciplinary team. It is the responsibility of the multidisciplinary team to educate, inform and evaluate the potential informed supervisors regarding their role specific to sexual offense issues. Safety plans shall be utilized to assist in defining an informed supervisor's role. The expectations of the multidisciplinary team regarding informed supervisors' responsibilities must be determined and agreed upon before implementation.

An informed supervisor is an adult, approved by the multidisciplinary team, who:

A. Is aware of the juvenile's history of sexual offending behaviors,

B. Does not allow contact with the victim(s) unless and until approved by the multidisciplinary team,
C. Directly observes and monitors contact between the juvenile, victim(s), siblings and other potential victims as defined by the multidisciplinary team,
D. Does not deny or minimize the juvenile's responsibility for, or seriousness of sexual offending,
E. Is aware of the laws relevant to juvenile sexual offending behavior,
F. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning,
G. Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning,
H. Understands the conditions of community supervision and treatment,
I. Can design, implement and monitor safety plans for daily activities,
J. Is able to hold the juvenile accountable for his/her behavior,
K. Has the skills to intervene in and interrupt high risk patterns, and
L. Communicates with the multidisciplinary team regarding observations of the juvenile's daily functioning.

Non-compliance by an informed supervisor should not be used as the sole reason for terminating a juvenile from treatment, placement, or to raise the level of care. If non-compliance by an informed supervisor interferes with the juvenile's progress in sex offense specific treatment there will need to be a recommendation to revise the level of involvement of the informed supervisor.

Therapeutic Care Provider

Therapeutic care providers provide corrective care and guidance beyond what is normally expected of a parent and informed supervisor to assist the juvenile in addressing special needs or developmental deficits that impede successful functioning. Therapeutic care providers are responsible for implementing interventions to address treatment goals. Standards for therapeutic care providers apply to care in both home and residential settings. Parents may provide such care only if they are active participants in the treatment process.

Therapeutic care providers are informed supervisors. Therapeutic care providers are line staff, counselors, foster parents, group home or Individualized Residential Treatment (IRT) parents, Residential Treatment Centers (RTC), DYRS, state-run facilities, day treatment and home-based service providers. Therapeutic care providers shall implement a continuum of care that includes intervention, nurturing, supervision and monitoring which supports the multidisciplinary team's goals and direction.

The therapeutic care provider who is also the treatment provider, must adhere to the treatment provider and therapeutic care standards and qualifications as outlined in Section 3.0.

Therapeutic care providers are responsible for providing informed supervision. In addition to the responsibilities described in the informed supervisor section, therapeutic care providers shall:

A. Not allow contact with the victim(s) unless and until approved by the multidisciplinary team,
B. Monitor contact between the juvenile, victim(s), siblings and other potential victims when approved by the multidisciplinary team,
C. Provide for the physical and psychological safety in the living environment and community for the juvenile,
D. Participate in containment planning and adhere to informed supervision guidelines,
E. Be involved in case management decisions as appropriate based on their role, or as requested by the multidisciplinary team,
F. Support multidisciplinary team decisions, and implement specific goals identified in the treatment plan,
G. Be educated on sexual offense dynamics and provide relevant information about the juvenile to the multidisciplinary team,
H. Respond to changes in risk factors and report observations to the multidisciplinary team,
I. Implement behavior management techniques and provide consequences and interventions to address negative choices,
J. Provide learning opportunities to interrupt behaviors that include, but are not limited to, elements of the offense cycle,
K. Provide opportunities for the juvenile to interact with positive male and female, adult and peer role models,
L. Provide activities that promote positive relaxation, recreation and play,
M. Make arrangements for, ensure transportation to and monitor attendance at all of the juvenile's appointments, and
N. Share information about special needs, patterns, successful behavior management strategies and information with the multidisciplinary team.

VII Responsibilities of School Districts

If the juvenile is enrolled in a school, the school district should designate a representative from the school or school district to participate as a member of the multidisciplinary team. The representative may be the resource officer, social worker, counselor, vice principal or other professional.

School Districts are responsible for the training of school representatives on the multidisciplinary team regarding juveniles who commit sexual offenses.

The responsibilities of the school representative on the multidisciplinary team may include, but are not limited to:

A. Communicating with the multidisciplinary team regarding the juvenile's school attendance, grades, activities, compliance with supervision conditions and any concerns about observed high-risk behaviors,
B. Assisting in the development of the supervision plan,
C. Providing informed supervision and support to the juvenile while in school,
D. Developing a supervision safety plan considering the needs of the victim(s) (if in the same school) and potential victims,
E. Attending multidisciplinary team meetings as requested, and
F. Participating in the development of transition plans for juveniles who are transitioning between different levels of care and/or different school settings.

5.0 VICTIMS AND POTENTIAL VICTIMS: CLARIFICATION, CONTACT AND REUNIFICATION

I. Defining Victim Clarification

Upon the request of the victim and/or victim parent(s)/guardian(s), the juvenile offender will participate and cooperate in victim clarification. Victim participation is never required and is sometimes contraindicated. Should the process proceed to an actual clarification meeting with the victim, all contact is victim centered and based on victim need.

The victim clarification process is designed to primarily benefit the victim. Through this process, the juvenile acknowledges and accepts that the victim has no responsibility for the offender's behavior. The specific questions posed to the juvenile or topics to be addressed must be clearly defined and the goals and purpose of such communication must be clear to all involved. Issues addressed include the damage done to the victim, family and/or secondary victims.

Clarification is a lengthy process that occurs over time usually beginning with the juvenile's reduction of denial and ability to accurately self-disclose about the sexual offending behavior. Following written work, clarification may then progress to verbal contact prior to or in lieu of face-to-face contact.

Secondary victims and significant persons in the victim's life are impacted by sexual offending behavior. Clarification with others (i.e.victim's parents, juvenile's parents, siblings, neighbors, fellow students) who have been impacted by the offense may be warranted in some cases.

II. MDT Role in Victim Clarification

A. Collaborate with the victim's therapist or advocate, representative of the Department of Justice, guardian, custodial parent, and/or foster parent, in making decisions regarding communication, visits and reunification.

B. Support the victim's wishes regarding contact with the juvenile to the extent that it is consistent with the victim's safety and well-being. A common dynamic in families that may occur is direct or indirect influence or pressure on the victim to have contact with the juvenile who has committed a sexual offense. An independent professional assessment regarding victim needs may be warranted prior to contact with the juvenile.

C. Arrange contact in a manner that places victim safety first. When assessing safety, psychological and physical well-being shall be considered. In addition, the following criteria must be met before contact can be initiated and approved by the multidisciplinary team:

1. An informed supervisor has been approved by the multidisciplinary team. If the supervisor is not known to the victim, then the victim's therapist, advocate or caregiver must be present if the victim is a child. This adult must meet the requirements of an informed supervisor as outlined in Section 4 of these standards.
2. The juvenile is willing to plan for contact, to develop and utilize a safety plan for all contact and to accept and cooperate with supervision.
3. The juvenile is willing to accept limits on contact by family members and the victim, puts the victim's needs first and respects the victim's boundaries and need for privacy.
4. The juvenile is willing to cooperate with family or third party disclosure related to risk as directed by the multidisciplinary team.

D. If contact is approved, the multidisciplinary team shall closely supervise and monitor the process including:
   1. The safety plan must have a mechanism in place to inform the multidisciplinary team and specifically the supervising probation officer of concerns or rule violations during the contact.
   2. Victim's and potential victim's emotional and physical safety shall be assessed on a continuing basis and contact shall be terminated immediately if any aspect of safety is jeopardized.

III. Victim Clarification

All procedures must be approved by the multidisciplinary team and specifically include the victim's therapist or advocate and/or a representative from the Department of Justice. The multidisciplinary team shall use the following criteria:

A. The victim(s) requests clarification and the victim's therapist or advocate concurs that the victim(s) would benefit from clarification.
B. Parents/guardians of the victim(s) (if a minor) and the juvenile are informed of and give approval for the clarification process.
C. The juvenile evidences empathic regard through consistent behavioral accountability including an improved understanding of: the victim's perspective; the victim's feelings; and the impact of the juvenile's inappropriate or offending behavior.
D. Any significant difference between the juvenile's statements, the victim's and corroborating information about the abuse has been resolved to the satisfaction of the multidisciplinary team. The juvenile is able to acknowledge the victim's statements without minimizing, blaming, or justifying.
E. The juvenile is prepared to answer questions and is able to make a clear statement of accountability, and give reasons for victim selection to remove guilt and perceived responsibility from the victim.
F. The juvenile is able to demonstrate the ability to manage abusive or inappropriate sexual interest/arousal specific to the victim.

G. Any sexual impulses are at a manageable level and the juvenile can utilize cognitive and behavioral interventions to interrupt inappropriate/deviant fantasies as determined by continued assessment.

IV. Contact

Contact includes verbal or non-verbal communication which may be indirect or direct, between a juvenile and victim(s). Contact is first initiated through the clarification process. Following commencement of the clarification process and upon agreement of the multidisciplinary team, contact may progress to supervised contact with an informed supervisor outside of a therapeutic setting.

V. Family Reunification

Family reunification is subject to Family Court approval. The multidisciplinary team shall make recommendations regarding reunification. Family reunification shall never take precedence over the safety of any victim. If reunification is indicated, after careful consideration of all the potential risks, the multidisciplinary team shall closely monitor the process. Even when indicated, family reunification can be a long-term process that involves risk and must be approached with great deliberation.

Reunification may only be considered when clarification has been accomplished AND:

A. The multidisciplinary team has determined that the juvenile has made significant progress toward goals and outcomes as outlined in Section 3.0.

B. The multidisciplinary team has determined the victim has the abilities to set age appropriate boundaries and limits, and ask for help.

C. The multidisciplinary team has determined the parents/caregivers have demonstrated the ability to provide informed supervision and demonstrate evidence of:

1. The ability to initiate consistent communication with the victim regarding the victim's safety, and
2. The family believes the abuse occurred, has received support and education, and accepts the potential for future re-offense, and
3. The family has established a relapse prevention plan that extends into aftercare and includes evidence of a comprehensive understanding of the inappropriate/offending behavior and implementation of safety plans.

The multidisciplinary team shall continue to monitor family reunification and recommend services according to the treatment plan. Family reunification does not indicate completion of treatment. Reunification may illuminate further or previously unaddressed treatment issues that may require amendments to the treatment plan.

6.0 DEFINITIONS

ASSESSMENTS
Standardized measurements, developed and normed for juvenile populations, used to test various levels of functioning, including: cognitive, neuropsychological, psychiatric, psychological, memory and learning, social and emotional, social stability, family dynamics, academic, vocational/career, sexual, accountability and offense characteristics and, level of risk.

BOARD
Delaware Sex Offender Management Board

CAREGIVERS
Parents or other adults who have a custodial responsibility to care for the juvenile. Caregiving is broadly defined as providing the nurturance, guidance, protection and supervision which promotes normal growth and development and supports competent functioning.

COMMUNITY SUPERVISION
When a juvenile has been adjudicated and sentenced to probation, he/she is considered to be under community supervision. The probation officer, assigned to the ISB unit in the Division of Youth Rehabilitative Services, supervises the juvenile.

COMPLETE CASE RECORD
A working file which includes the relevant criminal/legal reports, initial evaluations, all ongoing assessments, all case plans, all interventions and sanctions, all consents and releases of information and contact information of all professionals, parents/guardians and others identified as significant in a juvenile's case.

CONTACT
Any verbal, physical or electronic communication, that may be indirect or direct, between a juvenile who has committed a sexual offense and a victim or potential victim.

CONTINUUM OF CARE AND SERVICES
The various levels and locations of care, based on the juvenile's individual needs and level of risk; include treatment intensity and approach, and restrictiveness of setting. This continuum is within a given division or community agency and is also inter-divisional and inter-departmental.

DEPENDENCY AND NEGLECT
A civil court finding that a juvenile is in need of care and/or protection beyond that which that parent is, or has been, able or willing to provide. As per Title 10, Chapter 9, section 901 of Delaware Code, a child can be found dependent if the parent/caregiver "Fails to provide necessary care with regard to: food, clothing, shelter, education, health care, medical care, or other care necessary for the child's emotional, physical or mental health, or safety and general well-being."

DYNAMIC RISK FACTORS

For the purpose of these Standards, dynamic risk factors are considered changeable and must be addressed in sex offense specific treatment. The juvenile is held accountable and responsible for managing dynamic risk factors that are not based in the environment.

EMPATHY

The act of noticing, interpreting and responding to the affective cues of oneself and others. The ability to see a situation from another's experiential and affective perspective.

EVALUATION

The scope of various assessments, information gathered collaterally, and face to face meeting with the client constitutes an evaluation. The systematic collection and analysis of the data and interview is used to make treatment and supervision decisions.

GROOMING

Subversive actions perpetrated to gain access and trust of the victim and the victim's support system; training the victim and victim's support system to lower their guard. Behaviors are victim specific and include such things as: relationship building through shared interests or activities; development of a sense of specialness within the victim; shared secrets before sexual victimization.

INFORMED CONSENT

Consent means voluntary agreement, or approval to do something in compliance with a request. Informed means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives. Agreement including all of the following: 1) understanding what is proposed, based on age, maturity, developmental level, functioning and experience; 2) knowledge of societal standards for what is being proposed; 3) awareness of potential consequences and alternatives; 4) assumption that agreement or disagreement will be respected equally; 5) voluntary decision

INFORMED SUPERVISION

Specific to these Standards, informed supervision is the ongoing, daily supervision of a juvenile who has committed a sexual offense by an adult who:

a. Is aware of the juvenile's history of sexually offending behavior

b. Does not deny or minimize the juvenile's responsibility for, or the seriousness of sexual offending

c. Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning

d. Is aware of the laws relevant to juvenile sexual behaviors

e. Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning

f. Understands the conditions of community supervision and treatment

g. Can design, implement and monitor safety plans for daily activities

h. Is able to hold the juvenile accountable for behavior

i. Has the skills to intervene in and interrupt high risk patterns

j. Can share accurate observations of daily functioning
k. Communicates regularly with members of the multidisciplinary team

PROVIDER LIST
Roster of suppliers of specific services generated by the Sex Offender Management Board following the applicant's acceptance by the Application and Review Committee.

RELAPSE PREVENTION
An element of treatment designed to address behaviors, thoughts, feelings and fantasies that were present in the juvenile's instant offense, abuse cycle and consequently, part of the relapse cycle. Relapse prevention is directly related to community safety. Risk assessment must be used to develop safety plans and determine level of supervision.

RESIDENTIAL TREATMENT CENTER
A residential setting where employees interact with juveniles in a therapeutic manner regarding day-to-day living; may or may not include on-site sex offense specific treatment. In many programs the milieu is structured and operated with adherence to a specific milieu management model.

SAFETY PLANNING
Recognition/acknowledgement of daily/circumstantial/dynamic risks and purposeful planning of preventive interventions which the juvenile and/or others can use to moderate risk in current situations.

SECONDARY VICTIM
A relative or other person, closely involved with the primary victim, who is impacted emotionally or physically by the trauma suffered by the primary victim.

SEX OFFENSE SPECIFIC TREATMENT
A comprehensive set of planned therapeutic experiences and interventions to reduce the risk of further sexual offending and abusive behavior by the juvenile. Treatment focuses on the situations, thoughts, feelings and behaviors that have preceded and followed past offending (abusive cycles) and promotes changes in each area relevant to the risk of continued abusive, offending and/or sexually deviant behaviors. Due to the heterogeneity of the population of juveniles who commit sexual offenses, treatment is provided on the basis of individualized evaluation and assessment. Treatment is designed to stop sexual offending and abusive behavior, while increasing the juvenile's ability to function as a healthy, pro-social member of the community. Progress in treatment is measured by the achievement of change rather than the passage of time. Treatment may include adjunct therapies to address the unique needs of individual juveniles, yet always includes offense specific services by listed sex offense specific providers.

SPECIAL POPULATIONS
Any group of juveniles, who commit sexual offenses, who have needs which significantly differ from the majority of juveniles in this population. Special populations might include (but are not

limited to) juveniles who: are female; are developmentally disabled; have co-occurring psychiatric disorders; or, those who have learning disabilities.

STATIC RISK FACTORS

For the purposes of these Standards, static risk factors refer to those characteristics that are set, are unchangeable by the juvenile and may be environmental, or based upon other observable or diagnosable factors.

TERMINATION

Removal from or stopping sex offense specific treatment due to 1)completion; 2)lack of participation; 3) increased risk; 4) re-offense; 5)cessation of mandated sex offense specific treatment without completion (without accomplishing treatment goals); or, 6) by court order.

THERAPEUTIC CARE

Therapeutic care is intervention and nurturance, beyond normal parenting, which address treatment goals. It includes remediation of special needs and/or developmental deficits identified in the individualized evaluation focusing on increasing juveniles' potential and competencies for successful, normative functioning. Standards for therapeutic care apply to care in both in- and out-of-home living settings, yet such care may also be provided by parents who are active participants in the treatment process.

THERAPEUTIC CAREGIVERS

Caregivers who are responsible for implementing interventions to address goals to be accomplished in a therapeutic care setting.

TRANSITION POINTS

Transition points are marked by the planned movement from one level of care to another, return to the home/community or movement from one status to another [e.g. moving from DSCYF to the adult care system.

TREATMENT PLAN

Developed by the multidisciplinary team prior to the juvenile's completion of treatment; addresses strengths, risks and deficits relative to the release/completion and follow-up stage of treatment and supervision.