Evidence Based Outpatient Collaborative Treatment for Juveniles with Sexual Behavior Problems: A Prosocial Collaborative Model

CCOSO Central Valley Regional Chapter
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Contact Information and Bibliography

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- "Evidence-Based Practice with Juveniles." ATSA Forum, 2012.
- "Competency Status and Juveniles with Pending Sexual Offense Charges." In press, Perspectives, 2012.
- **Available at:** norbertralph.com

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Limitations

- **Remarks are limited to males only, but research indicates similar issues are likely to be the case for females.**
- **These issues are complex, always exceptions, unanticipated events, contingencies, etc. (The presentation is not meant to prescribe a specific course of action for particular cases.)**
- **Ethnic, sexual preference, gender issues, cultural, class, religious issues, always need to be accounted for.**


Executive Summary

Executive Summary

- California will start a mandatory model to be used with all adult registrants, The Containment Model, 7/1/12.
  - ~<50 teen registrants.
- Need models adapted to the needs of teens including 70% who are low to medium-low risk.
  - Low risk teens become high risk if not treated or contained.
  - Low risk teens (as a group) have victims too.
- The Collaborative Model- A model for teen JSO treatment.
  - 1. Comprehensive psychological assessment.
  - 2. Evidence based outpatient treatment for teens.
  - 3. Systematic collaboration.
  - 4. Case tracking on County level, public health approach.
- JSO refers to juveniles who sexually offend.

Presentation Summary

- JSO characteristics and risk categories.
  - Know our "customers", their distribution of risk and characteristics, a public health/epidemiological population based approach to treatment and risk management.
- Non-sexual factors to be addressed in JSO treatment.
  - Because risk to public safety and youth's treatment needs are not just regarding sexual issues.
- What type of treatment is effective?
  - Because we want to use effective methods.
- Comparisons: Adult Containment Model and Teen Collaborative Models.
  - Because adult models tend to dominate, and we need to clearly define what teen models require.
- The San Francisco JSR Program, a Collaborative Evidence Based Model.
  - Our "work in progress", "still under construction", "building the plane while flying it" (don't try this on the trip back).

JSO Characteristics- Who are these guys?

To know our "customers," their distribution of risk and characteristics, and to take a public health epidemiological population based approach to treatment and risk management.

Fast Facts

- 30-50% of child victims had an adolescent as perpetrator.
- 30% of adolescents who offend were victims too.
  - 16% of all males in general population were also victims.
- Approx. JSO rates-California.
  - San Diego has JSO rate of about ~24/100,000 (youth <18).
  - Sonoma has JSO rate of about ~22/100,000.
  - Alameda County has rate ~19/100,000.
  - San Francisco has rate ~28/100,000.
  - Very approximate estimates.

JSO vs Other Probation Teens

Seto & Lalumière, 2010, *Psychological Bulletin, 136*

- **Nonsexual offenses**
- Criminal history
- Antisocial peers
- Substance abuse

- **Sexual offenses**
- Sexual abuse
- Physical abuse
- Emotional abuse/neglect
- Anxiety
- Low self-esteem
- Social isolation
- Learning disabilities
- Exposure to sex/pornography
- Atypical sexual interests

Evidence On Prosocial Skills And Thinking Deficits

- Research by Dr. Ralph with the Roberts 2, storytelling task, with probation, outpatient guidance clinic, and “normative” (non-probation) groups shows...
- Probation youth average 4 years behind in problem analysis and resolution skills compared to “normative” groups
  - A modifiable criminogenic risk factor.
- A small sample of JSO youth (N=10) were even lower than the general probation group
- Probation < Outpatients < Normative
- Higher scores identify probation sample correctly (ROC curves):
  - 92% using Problem Identification
  - 88% correctly using Problem Resolution
  - ROC very good. T4 levels ID thyroid disease correctly 86%, clinical signs ID strep correctly 79%

The JSORRAT-II

- JSORRAT-II developed from studying all JSO youth in Utah for 1990-1992.
- 636 youth studied.
- Prevalence rate of JSO offenses, 39.2/100,000, youth <18.
- Primarily white (76%), all male.
- Looked at sexual recidivism only, with up to 10 year follow up.
- Looked at a variety of factors and to see if they predicted sexual recidivism.

Base Rates for Utah sample

- Juvenile sexual recidivism = charge for a new sex offense prior to age 18
  - Base rate = 13.2%
- Adult sexual recidivism = charge for a new sex offense as adult (prior to 2004)
  - Base rate = 9.1%
- Anytime sexual recidivism = charge for a new sex offense at anytime (prior to 2004)
  - Base rate = 19.8%

JSORRAT-II variables

Grouping of Variables for Analyses

- Variables were organized into families, groups, and subgroups based on conceptual similarity
- Example:
  - Family = victim of child abuse
  - Groups = sexual abuse, physical abuse, emotional abuse, and neglect
  - Subgroups = types of specific abuse, number of types of abuse, frequency of abuse, etc.

Ten Variable Families

- Sexual Offending History
- Sexual Offense Characteristics
- SO Treatment History
- Abuse History
- Mental Health Diagnoses
- Mental Health Treatment History
- Special Ed. History
- School Discipline History
- Family Instability
- Non-Sexual Offending History

The JSORRAT-II Items

- **See handout, last page.**

Notable Factors Excluded from JSORRAT-II

Offense Characteristics

Did the offender ever perpetrate a charged sexual offense alone or as a leader of a group?	N	Recid	%	Chi sq. 13.85	P level <.0005
No	185	10	5.4%		
Yes	451	74	16.4%		

Mental Health Diagnoses

**Was the offender ever diagnosed with a self-regulatory disorder? (ADD, ADHD, Impulse Control, Conduct, or Oppositional Defiant Disorder)?	N	Recid	%	Chi sq. 26.89	P level <.0005
No	478	44	9.2%		
Yes	158	40	25.3%		

Family Instability

**Did the offender experience physical separation from biological or adoptive parents prior to age 16?	N	Recid	%	Chi sq. 42.40	P level <.0005
No	509	45	8.8%		
Yes	127	39	30.7%		

**Severe difficulty relating to siblings (no sibs=no)	N	Recid	%	Chi sq. 27.70	P level <.0005
No	468	42	9.0%		
Yes	168	42	25.0%		

** Variables with two asterisks made a unique contribution to the prediction of juvenile sexual recidivism relative to other variables in the same family and also contributed uniquely beyond the sex offending history variable family (or were in that family).

JSO Risk Groups
Population Estimates

- Since Epperson had complete sample of whole state, can make population estimates.
- Can’t be used to estimate for other states, and may be secular trends (changes over time).
- Can be useful to have some idea of what different risk groups contribute to total victim population. Important for planning on a population level.

JSO Risk Groups
Estimates for Victims

Category	Score	Recid.	% Recid.	N in Cate.	% Total Sample	Vict.	Cum Vic.
Low	0-2	3/305	1%	305	48%	>=3	>=3
Mod Low	3-4	9/137	7%	137	22%	>=9	>=12
Moderate	5-7	26/107	24%	107	17%	>=26	>=38
Mod High	8-11	28/65	43%	65	10%	>=28	>=66
High	12+	18/22	82%	22	3%	>=18	>=84

JSO Risk Groups and Epperson's Utah Study

- **Low and Mod-Low Group: In Epperson's research 70% of JSO youth had a total 3% risk of sexual recidivism.**
- **Mod-High and High Group: 13% of JSO youth have a ≥40% risk of recidivism.**
- **If you have a 100 JSR youth, and follow them until age 18, look at future new victims, then do the math, for the Utah sample:**
  - **Low and Mod-Low group will on average have ~≥ 15 new victims**
  - **Mod-High and High risk group will have at least ~≥ 46 new victims.**
  - **Low and Mod-Low group risk kids produce new victims too.**

JSO Risk Groups and Epperson's Utah Study- Cont.

- Worling (2012) notes low risk youth ***may*** become high risk youth if not treated, and ***will*** likely be high risk if given wrong treatment (residential/youth prison).
- May be able to prevent low risk youth from becoming high risk youth by correct treatment.
- In Epperson's Utah study, youth who did not complete JSO treatment, had 3x the recidivism of those who did complete (30% vs 10%).
  - Get them the right treatment the first time.
- Important to differentiate risk level for different groups, and containment needs.
  - Risk, Needs, and Responsivity approach.

JSO Assessment and Treatment Should Not (Just) Be about Sexual Offending:

JSO Therapists Think about Sex Too Much

Because risk to public safety and youth's treatment needs are not just regarding sexual issues.

JSO Assessment and Treatment
Non-Sexual Issues

- Assessment and treatment of JSO youth has usually focused on problematic sexual elements of the JSO youth's history and functioning.
- Research and rationale that JSO assessment and treatment should also focus on other areas for the following reasons:
- 1. Nonsexual recidivism is over three times higher than sexual recidivism for JSO youth in treatment. One JSO study found that a treatment group had an 8% sexual recidivism rate versus the comparison group which had a 46% rate, and the nonsexual recidivism rates were 29% versus 58%, respectively (Borduin, Schaeffer & Heiblum, 2009).
- Another study found that the treatment group had a 20-year recidivism rate of 9% compared to 21% for the comparison group for sexual offenses, and 35% versus 54% recidivism for any offense (Worling, Littlejohn, and Bookalam, 2010).
- Akakpo and Burton (2011) found in their sample of JSO youth in residential treatment, almost 50% had used strong armed methods to commit robbery, or carried a hidden weapon, in addition to an adjudicated sexual crime.

JSO Assessment and Treatment
Non-Sexual Issues- Cont.

- 2. Deficits in Prosocial skills has been identified as a treatable risk factor for general recidivism (Ralph, 2011) .
  - Treatment: Aggression Replacement Therapy.
- 3. JSO youth specifically and probation youth generally have a high level of co-morbid psychiatric and neuropsychological conditions.
- Psychiatric and educational treatment of these conditions is important for the youth's future life functioning, reducing symptoms, and may assist with reduction of sexual and nonsexual recidivism.
- The Commission on Youth, Commonwealth of Virginia (2011), reports regarding JSO youth:
- JSO youth have difficulties with impulse control and judgment.
- Up to 80% have a diagnosable psychiatric disorder.
- 30 to 60% exhibit learning disabilities and academic dysfunction.

JSO Assessment and Treatment
Non-Sexual Issues- Cont.

- 4. Research from Multisystemic Therapy indicates modifiable criminogenic risk factors for sexual and nonsexual recidivism (Borduin, Schaeffer, & Heiblum, 2009). Includes:
- Family Factors: Low parental monitoring, high conflict, & low affection
- School: Low school involvement & poor academic achievement
- Delinquent peers

JSO Assessment and Treatment Should Not (Just) Be about Sexual Offending- Cont.

- 5. Pedophilic interests for JSO youth is rare, perhaps less than 1%.
- DJJ (California youth prison) report no youth w/ pedophilic/paraphilic interests.
- Dr. Blasingame, Redding, CA, 20 years of experience with JSO programs estimates 5% of youth he has seen in outpatient and residential programs have pedophilic/paraphilic interests.
- Teen Triumph in Stockton and Gateway in Roseville note similar levels.
- Gateway, Roseville, notes most all of the JSO kids they have feel inadequate, and kid victims are the only ones they feel comfortable with. As social skills increase, they develop age appropriate interests.
- Secure detention facility in New Jersey reports about 1%, 3 of 300 youth had pedophilic interests.
- Worling (2012) notes pedophilic interests in JSO youth are low.

JSO Assessment and Treatment Should Not (Just) Be about Sexual Offending- Cont.

- 6. JSO youth have significant rates of victimization regarding sexual and physical abuse. This suggests victimization issues need to be a focus of treatment for JSO youth.
- Ford and Linney (1995) found the rate of sexual victimization for the juvenile child molester was 50%, compared to 17% for the juvenile rapist, and 17% for nonsexual violent offenders. They also report 25% to 50% of teen offenders experienced physical abuse as children.
- Also the Commonwealth of Virginia (2011) reported 20% to 50% of JSO youth have histories of physical abuse, and 40% to 80% have histories of sexual abuse.

JSO Assessment and Treatment Should Not (Just) Be about Sexual Offending- Cont.

- Conclusion:
- Primary emphasis for assessment and treatment of JSO youth needs to be on sexual offending. But…
- Sole focus on sexual offending may miss modifiable risk factors for:
- 1. Reducing recidivism and number of victims.
- 2. Improving functioning of JSO youth to lead prosocial lives.


Is JSO Treatment Effective?
What is Effective?
Because we want to use effective methods.

Is JSO Treatment Effective?

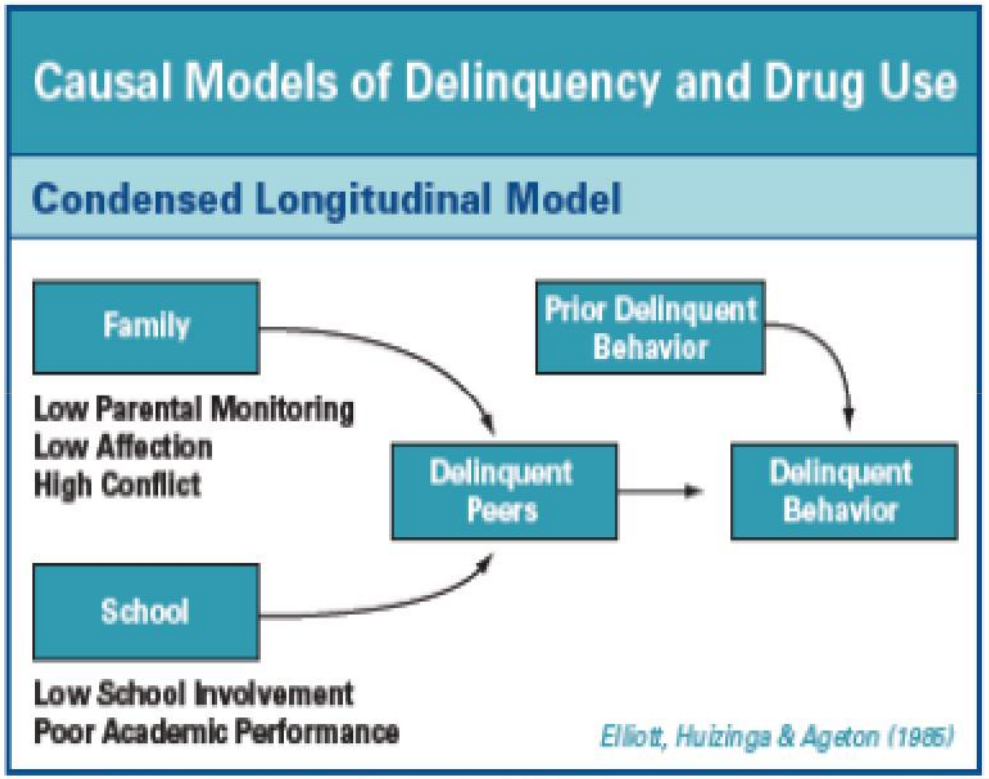
- **Reitzel and Carbonnel (2006),**
  - **Meta-analysis 9 studies of JSO treatment, sample size=2968.**
  - **JSO programs sexual recidivism 7.37% versus no treatment 18.93%.**
- **Borduin, Shaffer, and Heiblum (2009)**
  - **Multisystemic Therapy (MST) had an 8% sexual recidivism vs. other group 46%. High risk population.**
- **Worling, Littlejohn, and Bookerlam (2010)**
  - **Graduates of the SAFE-T Program, Toronto, 20 year sexual recidivism rate of 9% vs. 21% comparison group.**
- **Ralph (2012)**
  - **Randomized trial with JSO youth at Teen Triumph using Aggression Replacement Training. Large treatment effect.**

Teen Triumph Study

- Ralph (2011)
  - Randomized trial with JSO youth at Teen Triumph using Aggression Replacement Training
- Results: Two of six scales showed significant outcome:
- Critical Items: $\beta = -3.33$, $t\ (15) = -2.62$, $p = .01$
- Somatic: $\beta = -2.36$, $t\ (15) = -2.30$, $p = .04$
- Critical Items: Assesses severe psychiatric sxs, e.g., paranoid, OCD, psychotic, suicide, eating disorder.
- Somatic: Headaches, dizziness, stomachaches, bowel, pain.
- The ART type intervention may have improved social functioning, increased actual and expectation of social competency, increased optimism about future expressed as change on these scales.
- If one sided test was used, and $p<.10$ was used, then Interpersonal Distress scale would have $p=.076$. This scale measures anxiety and depression symptoms.
- Qualitative follow-up, youth reported being able to delay impulsive responses, use prosocial "if-then" thinking.

MST Risk Model and Treatment

- MST uses intensive, family center services, high supervision, high model fidelity.
- Empowers the family to develop skills for reducing risk factors.
- Improves social skills to increase friendship and age appropriate relationships.
- Can these factors be used w/out MST fidelity and supervision model?



What is Effective for General Probation Youth? Lipsey (2009)

- JSO treatment programs needs to use effective methods used to reduce general recidivism, because of non-sexual recidivism has 3x the rate of sexual recidivism, and has victims too.
- Interventions with counseling or skill building were more effective than those based on control or coercion.
- Interventions were more effective with youth with higher levels of delinquency risk. < lo risk.
- Interventions were effective if implemented with high fidelity. The largest mean effect size were those interventions that used cognitive-behavioral methods, but other methods such as mentoring also were effective.

What is Effective for General Probation Youth? Lipsey (2009)- Cont.

- Approaches that used only deterrence and discipline, such as boot camps or "Scared Straight" programs were associated with an increase in recidivism.
  - Boot camp w/ skill building, then you got something! Riverside Co.
- Interventions were effective if well implemented and targeted at appropriate youth, not only more well known or "brand name" interventions.
- "It does not take a magic bullet program to impact recidivism, only one that is well made and well aimed" (Lipsey, 2009, p. 145).
- If you design a program well, then track outcomes, you can modestly assert that your methods are evidence based, and comparable to those similar with good outcomes.
  - Build in a program evaluation and outcome component.
  - If programs use evidence based methods but don't track outcomes, is their program evidence based?

Containment and Collaboration Models:
Adult & Teens

Because adult models tend to dominate, and we need to clearly define what teen models require.

CASOMB Model
The California Way

- **Legislation has created the California Sex Offender Management Board (CASOMB), which certifies all programs and providers in California beginning in July 2012.**
- **The legislation and regulations mandate program features.**

CASOMB Model
The California Way- Cont.

- Containment Model: mandates:
  - Containment team: 1 Probation officer, 2. Sex offender treatment provider, and 3. Polygraph examiner.
  - Sex offender specific treatment.
  - Relapse prevention mandated.
  - Use of the term Sex Offender.
  - Risk, Needs, and Responsivity.
  - Use evidence based and emerging best practices to the greatest extent possible.
  - Assessment-Based Treatment and Supervision Planning.
    - Includes specialized psychological/neuropsych testing if required.
  - Victim advocacy.
  - Extensive offender related treatment goals.

CASOMB Model- Cont.

- Cooperative Features of Containment Team
- Release of information and consents
- Exchanging information in support of each other's roles
- Ongoing monitoring of behavior
- Cross-training
- Creating resources
- Problem-solving
- Joint decision-making
- The model is not designed for teens per CASOMB

CASOMB Containment Model and Teen Treatment

- Containment Model, though excellent, developed for adults, not for teens.
- Model has limitations for teens.
- Polygraph Use:
  - Programs particularly with high risk youth find it useful, but..
  - Polygraph: Polygraph with JSO youth shows some juveniles disclose more information (Worling, 2012).
  - But no research directly correlating “more information” about past offending with better or treatment outcomes, but this is true for many factors.
  - Objections of defense attorneys in some jurisdictions (e.g., SF) does not permit use.
  - Adds to negative narrative in treatment, e.g., that youth need to be caught lying, need to be coerced.
- Narrative: JSO youth use denial, prevarication; treatment should emphasize control, not collaboration; motivation for positive behavior is punishment.

CASOMB Containment Model and Teen Treatment- Cont.

- **Sex offender specific treatment :This implies treatment focused on the sexual offense and preventing sexual recidivism.**
  - **Most JSO youth do not have an underlying primary sexual disorder although the crime was sexual.**
  - **~70% have 3% risk of sexual recidivism, but 13% >= 40% risk.**
  - **Pedophilia is rare with JSO youth.**
  - **Nonsexual recidivism is ~3x higher than sexual.**

CASOMB Containment Model and Teen Treatment- Cont.

- Emphasis should be on the offense and relapse prevention, but also:
- 1. prosocial skills training
- 2. treating co-morbid psychiatric, learning, substance abuse.
- 3. working with family to provide control, support, supervision.
- 4. also the sexual aspect, sexual education, healthy sexual behaviors.
- 5. Collaboration with youth and family where possible
  - The worst is over for the youth and family.
  - Probation, therapist, and youth and family all want the youth to live “good prosocial lives” and have no future arrests. (Who would disagree).
  - Lets work together to make it happen.
  - Different narrative and reality than Containment Model.

The Washington State "Prosocial" Model

Kecia Rongen, Washington State Juvenile Rehabilitation Administration,

- Because of the limitations of relapse prevention model developed primarily from adult treatment models.
- New Model:
- Not using the term "sexual offender" re clients
- Not using the sexual offense cycle as part of treatment
- Not using offense disclosure in group settings
- Not using coercive and confrontation approaches
- Using a Healthy Living Plan, a strength based relapse prevention plan
  - Helps youth define personal goals and avoiding abusive behaviors and high risk situations
- Use ART, Functional Family Therapy, and dialectical cognitive behavioral techniques
- Research on the effectiveness of this model with JSO populations is pending.

The Prosocial Model (Ralph, 2012)

- **The Prosocial Model ID's the same behaviors as due in part to deficits in social perception, moral reasoning, emotional regulation, and social skills**
- **The intervention is to "teach to" the deficits: using social skills, anger control, and moral reasoning modules**
- **Give youth tools and hope that they can lead a "Good Life", and find your *OWN* reasons to change (like MI).**
- **Changes the narrative that influences treatment for youth, family, provider, and probation.**
- **Our narrative about youth influence the youth's and other's image of him.**
- **The Prosocial model invokes a different "narrative" for the youth to carry forward in life, that is more accurate, and less likely to be counterproductive.**

The Collaboration Model
An Alternative for Adolescent Treatment

- A Collaborative Model is more appropriate for JSO treatment in the same way juvenile justice is more of a collaborative context compared to adult.
- Goal of juvenile justice system is public safety and welfare of youth.
- While part of juvenile system is adversarial, post-adjudication it needs to be collaborative.
- The “narrative” of the model is we will work to help you have a good life.
  - A good life means no sexual or non-sexual recidivism.
  - A good life means developing prosocial skills and relations which have “win/win” outcomes.

Public Health/Epidemiological Perspective

- Adopting a view of managing the total population "at risk," not just cases a program is treating.
- Need professionals JSO "savvy" group to track kids.
- In California, best done at county level, but variable approaches for management.
  - Alameda, Sonoma, San Diego, and San Francisco track total youth population with sustained sex charges. Others don't.
- There are kids who get missed, lack of treatment, inadequate treatment, wrong treatment, and over-treatment.

The San Francisco Juvenile Sexual Responsibility Program

A Collaborative Model

Build a program and they will come

The JSR Program in SF
A Collaborative Model

- Program is an outpatient program; collaborative effort between:
- Special Programs for Youth, Department of Public Health.
- Juvenile Probation Department.
- Done with consultation with judges, public defenders, and district attorney.
- Presented to the Mayor's Child Abuse Council with police, victim assistance, and victim treatment agencies.
- A teen specific model, using elements of Containment Model.

The JSR Collaborative Model

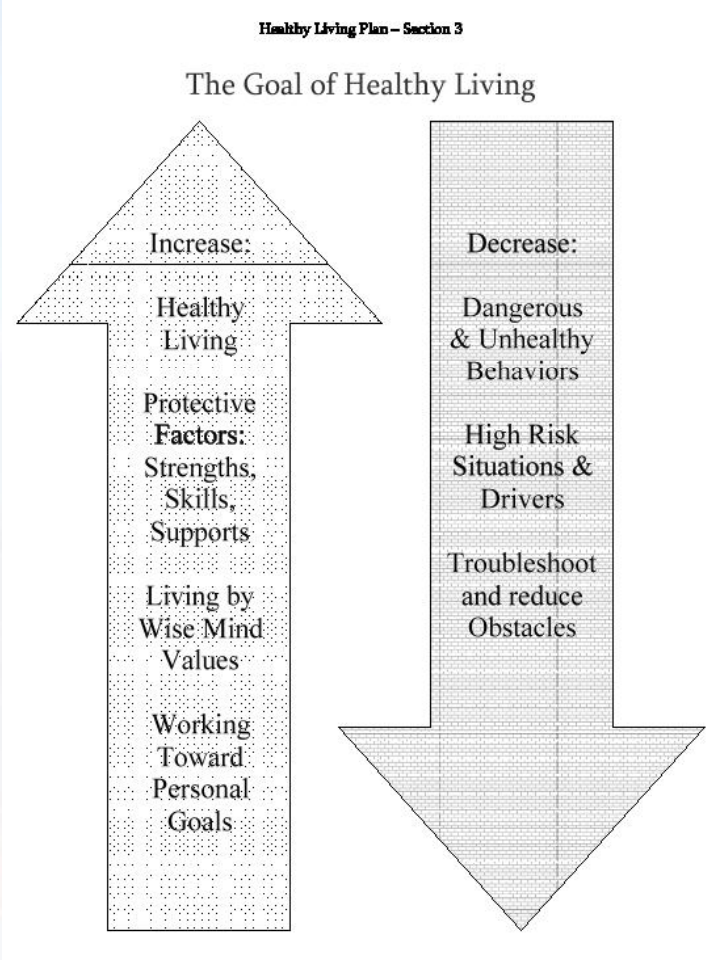
- Collaboration team:
- 1. Probation Officer, 2. JSR therapist, 3. Youth/Family, 4. collaboration with AIIM Higher (treatment linkage), 5. collaboration with Public Defender services including educational advocacy.
- A comprehensive psychological and risk management evaluation is done.
- Use of Prosocial Curriculum, e.g. Aggression Replacement Training. Evidence based.
- Use Relapse Prevention/Sexual Offense Cycle: Pathways, Road Maps. Not evidenced based.
- Not use term "Sex Offender" for program or teens.
  - Use: Juvenile Sexual Responsibility Program.
- Separate parent meeting and consultation monthly. Targets MST variables: family relations, school involvement/ performance, delinquent peers.

The JSR Collaborative Model- Cont.

- Focus in part on non-sexual re-offending since with JSR youth, nonsexual offenses may create victims too.
- Focus on non-delinquent treatment needs, e.g., substance abuse, PTSD, depressive conditions, anxiety conditions, ADHD, learning disabilities, educational failure, high risk sexual behaviors, etc.
  - AIIM Higher makes treatment/link with these areas.
- Focus on school/academic functioning.
  - Education grant through Public Defenders Office has MSW and lawyer for educational advocacy and case management.

JSR Collaborative Model

- **JSR treatment has two foci:**
- **Relapse prevention; reduce risky situations and recidivism.**
- **Promote prosocial behaviors, strengths, future goals, and age appropriate experiences.**



JSR Assessment in SF

- All youth with a sustained JSO charge in SF are referred for JSR assessment.
- The JSR assessment is provided to probation to assist with rational and objective treatment planning.
- Uses evidence based assessment techniques, such as JSORRAT-II, mandated for use by the Chief Probation Officers of California, and the State Authorized Risk Assessment Tool for Sex Offenders (SARATSO) Committee.
- Assessment is written report, but not through court order.
- Requires signed consent by parent since DPH is separate.
- Evaluation looks at:
  - 1. Risk to the community for sexual and nonsexual offenses.
  - 2. Treatment needs for delinquent and non-delinquent problems. How can we help them be a more effective prosocial individual.

Comprehensive Psychological Evaluation

- **Each youth receives a comprehensive psychological evaluation.**
- **Consistent with guidelines for court ordered evaluations through the San Francisco Alienist Panel.**
- **Review of Records:** from probation and other sources with annotation of important information.
- **Interview with Probation Officer:** regarding information and relevant records.
- **Interview with Defense Attorney:** regarding information and relevant records.
- **Interview with Parents:** regarding referral issues, family relations, peer and delinquent influences, school adjustment, sub abuse, violence trauma, mental health hx, aggression problems, prosocial activities, DSM IV symptoms, criminogenic factors. Also developmental hx; prebirth hx, marital issues, preg hx, fam med hx, mat/pat sub abuse, perinatal hx and birth weight, early growth, developmental milestones, school behave and learning hx, spec ed hx, function at home, etc.
  - **Include hx of sexual behavior problems.**
  - **Parent knowledge "beliefs" regarding offense**.

Comprehensive Psychological Evaluation- Cont.

- **Interview with Youth:** regarding referral issues, family relations, peer and delinquent influences, school, sub ab, violence trauma, aggression problems, mental health hx, prosocial activities, DSM IV symptoms, criminogenic factors.
  - Also includes sexual history, experiences, and interests.
  - Youth narrative of offense and responsibility.
- **Mental Status Examination:** and behavioral observations.
- **Cognitive and Academic Achievement Batteries:** to identify youth with developmental delay, cognitive challenges, and learning disabilities.
- **Objective Assessment Instruments**: to assess personality and temperamental characteristics, and/or DSM IV type psychiatric symptoms.
- **Projective Assessment Instruments**: Roberts 2, assessing level of psychiatric distress and interpersonal problems solving.
- **Sexual Risk Evaluation Instrument:** JSORRAT-II.
  - Could also use J-SOAP-II or ERASOR 2.0.

Comprehensive Psychological Evaluation- Cont.

- **Specialized Assessment:** as needed, neuropsychological, competency evaluation, mental retardation, etc.
- **DSM IV Diagnosis:** rationale for diagnoses, based on history, records, collateral sources, interview with youth, mental status exam, and test results. Put limitations, rule outs, and cautions.
- **Recommendations:** linked to assessment findings, and based on research regarding what are effective treatments for specific problems in probation youth. Consideration should be given whether resources for recommendations are reasonably available.
- **Time Limits and Qualifications:** assessment shouldn't be used for more than a year. Also qualifications for assessing certain risk factor, e.g., risk of assault.

Comprehensive Psychological Evaluation- Cont.

- Different parts of evaluation differentially contribute to diagnostic assessment.
- For example:
- Can only assess reading disorder from IQ and academic testing.
- Can’t assess enuresis from IQ and academic testing.

Assessment during Treatment and at Discharge

- Assessment during treatment and at discharge is recommended.
- Every 3-6 months and at discharge.
- Could also use J-SOAP-II or ERASOR 2.0.
- Juvenile Sex Offense Specific Treatment Needs & Progress Scale by Righthand and associates is another option.
  - Research showing this predicts recidivism and other outcomes.
- See at end of handout.

JSORRAT-II Distribution of SF JSR Evals

- N=17, youth evaluated in past year.
- Ave age= 15.6
- All males.
- JSORRAT-II: Ave= 2.5, Median=2.0, Mode=1; Range=0-9
- 53% - 2 or less, Low range.
- 89% - 4 or less, in Low or Mod-Low range.
- Residential Comparison:
- Teen Triumph Residential Program:
  - JSORRAT-II score: Ave=5/ (range 2-11)

Treatment Options

- Treatment/Placement: Outpatient vs. residential vs. DJJ.
- JSR eval recommends to probation, decisions by MDT (placement team) and judge. Probation handles residential referrals.
- Outpatient youth referred to JSR/Probation committee to decide for suitability for outpatient JSR treatment.
  - Eligibility: Low to Med-Low risk, compliant with conditions of probation, likely to cooperate with treatment, reasonable parental cooperation/ control, and adequate home setting, no severe antisocial/gang behaviors.
- We have 8 slots for outpatient treatment, including 1 Sp sp. We are planning increase.
- Length of treatment is 6 months to 2 years.
- Outpatient options increase likelihood that low risk youth stay in community, and not put in high risk residential settings.

Factors to Consider for Outpatient JSR Treatment

- **Is there a competent parent/guardian?**
  - Can the parent reasonably track and manage the youth?
  - Do they believe the youth is a risk?
  - Any parental risk factors, transportation, long work hours, illness, high conflict relationship, hx abuse, substance abuse, criminal hx, psychiatric history.
  - MST factors- High hostility, low affection, low parental control.
- **School/Environmental assessment**
  - What type of housing? Neighborhood? Projects?
  - School setting, are there younger or vulnerable youth there.
- **Peers:** Delinquency, gang ties, out of control, substance abuse, etc.
- **Access to victim(s):** Same or different. Small children, etc.
- **Access to pornography,** e.g., internet, cell phone, iPad, etc.
- **Access to communication tools:** email, texting, IM, photo sharing, etc.

Factors to Consider for Outpatient JSR Treatment

Factors Increasing Risk

- Severity and chronicity of sexual acting out (bad stuff for long time).
- Multiple victims.
- Public (non-private) settings for offending.
- High and deviant sexual pre-occupation.
- Highly impulsive and/or very poor judgment.
- High use of pornography.
- Low cognitive functioning.
- Low anxiety about offense, even with treatment.
- Continued non-compliance with probation, school, parent, or treatment rules.
- Not making progress in treatment.
- Often don’t know some things until treatment started.

Case Tracking and Outcome

- Monthly meeting with probation to track:
- 1. Those with pending JSO charges, including “not competent” status.
- 2. Youth scheduled for JSO evaluation with sustained charges.
- 3. Those having completed JSO evaluation with sustained charges.
- 4. Treatment status (residential/outpatient) of youth evaluated.
  5. List of youth graduated.
- 6. Annual tracking of graduates for recidivism while juvenile.
- 7. Tracking of JSR youth in detention.
- Surprises almost every month, JSR charge discovered, transferred from different county, etc.

SF JSR Program Tracking and Case Staffing

- 2006-JSR program began after hiatus and resumed services for outpatient clients.
- 2009-Started joint meetings with juvenile probation.
- In 2009: N=8 JSR youth under supervision.
- In 2012: N=25 JSR youth under supervision.
- Still a mystery of where these youth came from.
- Build a program and they will come.

And that’s all folks

City and County of San Francisco