



***Community-Based Standards For
Addressing Youth Who Have
Caused Sexual Harm***

FOREWORD

Interventions with youth who have caused sexual harm are continually evolving. Empirically based studies are emerging in the field and guiding practice. Even this document's title seeks to change the focus from "sex offenders" to youth who have caused sexual harm as we move towards a more comprehensive view of these youth.

A shared philosophy provided the impetus for creating these standards. We have learned much about this population: how they are similar to other youth, how they are different from youth in the general population, as well as different from each other. We are learning that youth can, and often should be treated in their community to maximize healing and growth, and to development into the best adults they can be. Review of current trends in emerging literature validated a commitment to develop standards for empirically driven practice.

We are professionals interested in contributing to the ongoing improvement of practice with youth and expect this document to be revised as new information is gathered. We therefore offer these standards as benchmarks for programs to work toward as they strive to best serve the youth, their families, and the community. The full document is available to all for distribution through these websites: resourcesforresolvingviolence.com and provcorp.com.

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INTRODUCTION

The purpose of this document is to provide a foundation for a comprehensive, community-based response to sexual harm by youth. Evidence-based studies are increasingly guiding treatment reform in youth violence prevention and sexual harm by youth (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002; Office of the Surgeon General, 2001; Borduin & Schaeffer, 2001). These studies are influencing a paradigm shift in service provision. Research indicates that “most adolescent sex offenders pose a manageable level of risk to the community” (Chaffin, Bonner, & Pierce, 2003, p. 2) and intensive home-based treatment currently offers the most promising successful long-term outcomes for youth who have caused sexual harm (Chaffin, 2006; Borduin & Schaeffer, 2001; Borduin, Henggeler, Blaske, & Stein, 1990).

Such information challenges conventional wisdom in the field of sexual harm by youth (Chaffin & Bonner, 1998; National Adolescent Perpetrator Network, 1988, 1993). Initially there was little research to guide understanding and intervention. There was little widespread knowledge in our society about the nature, significance, and breadth of sexual harm by youth. The field has suffered as a result, and program development has been based upon treatment modalities and interventions for which there is inconclusive evidence. As more research focuses specifically on youth who commit acts of sexual harm, evidence is indicating that some of our early assumptions and understandings led to interventions that have been less than optimal in helping to stop sexual abuse. These standards are a beginning effort to correct such problems. This document will require updating and revision as new research renders it anachronistic.

The World Health Organization (2007) defines sexual health as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

Floyd Martinson, in a seminal text on juvenile sexual offending (Ryan & Lane, 1997), states that “sexuality is seldom treated as a strong or healthy force in the positive development of a child’s personality in the United States. We are not inclined to believe that our children are sexual or that they should be sexual in any of their behaviors. Although it is difficult to generalize in our pluralistic society, there is typically no permission for normal child sexual experiences. Children are not taught to understand their sexual experiences or to anticipate sexual experiences as enjoyable. Rather, they are taught to be wary of most sexual experiences, both interpersonally and intrapsychically.” (p. 36)

A dearth of research on childhood and adolescent sexual development impedes knowledge about the full range of youthful sexual expression from that which is considered normal to that which is considered pathological. American values and beliefs greatly impact community responses to sexual harm by youth. Historically, responses have swung like a pendulum between “boys will be boys” laissez-faire attitudes of doing nothing to gross overreaction in which young children are referred to as sexual predators. According to Lanning (1987), 85% of juvenile sexual offending is “adolescent experimentation.” The fluid nature of sexual development and insufficient evidence regarding the full range of sexual harm and violence prevent empirical categorization and standardized responses across a continuum of sexual harm by youth. When normal youthful sexual experimentation is addressed in the same way as juvenile sexual harm, communities are at risk of causing greater harm and injustice. The task of creating community-based standards for responding to youth who have caused sexual harm must address vital issues of screening and assessment in order to provide a reasoned approach for determining the existence and extent of sexual harm, enhancing sexual health and well-being for everyone.

The community-based standards, founded upon emerging research, are designed to integrate new and exciting findings that inform successful treatment outcomes, provide a guide for treatment that is safe for all members of a community, and are cost-effective. The standards are not designed to supplant existing residential and/or state standards, but rather to fill in gaps, inspire, and provide a reference point for a comprehensive continuum of care.

The hope is that these standards enable service providers to intervene with increased confidence in the efficacy of their efforts to stop sexual harm by youth.

A glossary of operational definitions is provided at the end of this document.

Dedication

These standards are dedicated to the Kindred Spirits without whom the creation of this document would not have been possible.

Acknowledgements

We most sincerely and gratefully acknowledge the efforts of youth who have caused sexual harm, and their families, to stop the behavior and heal the pain of sexual abuse.

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Mission

Our mission is to provide empirically driven standards of care for services in community-based settings to address youth who have caused sexual harm.

Vision

Our vision is an evidence-based field of practice for identifying and addressing the full range of sexually harmful behavior by youth.

Philosophy

Achieving Our Mission: All standards illustrate our mission by reflecting our values and vision.

Do No Harm: Services are designed to screen for the existence of sexual harm. When sexual harm by youth is identified, holistic assessment establishes a foundation for effective treatment. All services are provided in the least restrictive setting for all involved in a manner that does not cause harm or injustice.

Respect: All interaction is based upon thoughtful consideration for basic human rights and dignity.

Quest for Excellence: These Standards of Care should be continuously improved by evaluating effectiveness and efficiency. Excellence is demonstrated by staff, determined by prevention of criminal behavior, and evaluated by youth and families for whom services are provided. Adherence to Standards of Care requires commitment to providing necessary resources, staff development, and training to maintain excellence in service provision.

Efficiency: All services are designed and delivered in the most cost-efficient manner. Efficiency is measured through the relationship of cost to outcomes. Successful outcomes are achieved through efficient utilization of resources.

Ecology: Family and community are central to life experience. Each youth and family involved in treatment is part of a larger community with established institutions and agencies designated to support and assist these youth as they move toward adulthood. All services are provided in conjunction with this support.

Diversity: Respect for the diverse nature of families for whom services are provided is paramount. Support is given without regard for gender, race, ethnicity, sexual orientation, religion, nationality, culture, and financial status.

Community Education: Educating schools, recreational and athletic organizations, faith communities, youth, courts, social service agencies, mental health providers, doctors, and any other providers of services to youth and families about dynamics of sexual harm by youth is an important step toward achieving outcomes that will provide for long-term positive change.

Individualized Treatment: Interventions will be provided based on the individual and collective strengths and needs of each youth and family. Treatment necessary for each youth and family will be determined based on initial and ongoing assessment throughout treatment.

Hope: All services provided are intended to instill hope. Hope is central to the healing process. Service plans are developed and maintained in accordance with the belief that youth and their families will make progress in their goals of healing.

Relationships: Healing occurs within the context of relationships. Families are able to benefit from services when they are provided with nonjudgmental, genuine, support and empathy.

Healing: Healing is the ability to embrace and celebrate life through attention to physical, social, psychological, and spiritual needs. Service provision is guided by the belief that youth and families can heal from the pain that influenced the need for services. Healing is the basis for leading productive and fulfilling lives by learning to manage pain in ways that do not cause harm. These Standards of Care promote service provision that supports youth and families through clinical assessment and treatment, based upon strengths, resources, and attributes of resiliency focusing on goals of treatment.

Resilience: All services are designated and provided in a manner that embraces each participant's ability to master tasks required for healing. All children and families are competent to initiate service goals and collaborate in the design and maintenance of those goals. By supporting client's rights to make decisions, we enhance their ability to respond to the healing process.

Successful Outcomes: All services are based upon research related to harm reduction. Desired outcomes are established with each youth and family.

Continuum of Care: All services are designed and maintained to facilitate seamless transitions throughout a full continuum of care. Clinical assessments guide service provision in the least restrictive environment.

Core Values

Sexual harm hurts people. Concern for victims and their need for respect, healing, empowerment, and ongoing safety must be both the driving force and guiding principle that informs all service provision.

Every member of a community deserves to be safe. Youth who have caused sexual harm and all victims or potential victims must be assured physical and emotional safety. Assessment of safety is an ongoing process as any number of factors may change, making a situation unsafe for treatment. Thorough assessment assures services are provided based on the needs of each youth, family, and community.

Treatment is guided by current research-based, best-practice standards for assessment and treatment. The field of study involving treatment of sexual harm by youth is relatively new and constantly advancing. Best-practice standards will need to be updated as new findings are validated.

The most effective treatment is holistic in character. Youth who cause sexual harm should not be defined by this behavior. In approaching a youth as a multifaceted person, treatment will address needs that may seem removed from the issues of sexual harm. By addressing these needs, treatment can contribute to the long-term success and development of a youth as a valuable member of the community.

When a safe environment can be established, treatment provided in the community offers more opportunities for long-term success and safety. Collaboration among treatment providers, families, schools, social services, courts, etc., will ensure more of a safe environment as it allows the youth to be more connected to family, friends, community organizations, recreation, education, jobs, etc. As these efforts are made and community members are educated about sexual harm, future sexual harm can be prevented.

Treatment is informed by cultural competence. When treatment is individualized based on the strengths, needs, cultural uniqueness, and perspective of the client and family, treatment will be more successful.

Treatment providers have specialized training. In addition to meeting licensing requirements as designated by a treatment provider's professional discipline and state regulations, specialized training for responding to sexual harm by youth should be an expectation for practice in the field.

I. SCREENING AND ASSESSMENT STANDARDS

1.) Screening

Standard: Programs serving youth and families screen all youth with questions designed to identify sexual harm by youth.

Rationale: Early identification of youth who have caused sexual harm is the first step toward effective identification and prevention of sexually harmful behavior (Center for the Study and Prevention of Violence, 2006; Ryan, 2005).

Evaluation Measures:

1. The program has screening questions designed to identify sexual harm by youth.
2. The program demonstrates use of the screening questions with all youth served.
3. All programs serving youth of any age have documented policy and procedures for staff to respond to sexually harmful behaviors based upon current empirical evidence.

2.) Reporting Suspected Sexual Harm by Youth.

Standard: As required by local law, the program reports all known or suspected incidents of sexual harm to child protective services and/or law enforcement.

Rationale: All reporters mandated by law are required to report suspected child sexual abuse. Reporting incidents to the appropriate authorities reflects the seriousness of the harm triggered by the behavior. It also accesses the investigative powers of law enforcement, increases the likelihood that there will be appropriate community supervision, and improves the accessibility to relevant services for all associated with the incident. Further, reporting protects the professional from liability inherent in not reporting potentially dangerous behavior.

Evaluation Measures:

1. The program has a written policy that requires reporting all incidents of child sexual abuse to the designated authority.
2. All child-serving agencies maintain documentation when submitting child protective service reports and/or law enforcement reports.
3. All child-serving agencies maintain documentation of staff training regarding mandatory reporting.

3.) A Qualified Response to Youth Who Have Caused Sexual Harm

Standard: Once screening indicates the likelihood that the youth has caused sexual harm, a process is initiated to provide a timely and relevant response reflecting an ecological perspective. A Qualified Mental Health Professional (QMHP) with specialized training, as identified in Standards 23 and 24, facilitates this process.

When screening determines normal, age appropriate sexual experimentation, no intervention is indicated. When screening determines an absence of sexual harm but indicates cause for concern, youth are referred for sexual health education and services that include information about biology, relationships, and applicable laws.

Rationale: Research indicates that early intervention has the potential to reduce the risk of further sexual harm (Ryan, 2005). Early intervention with youth may identify factors indicating a need for a specialized assessment and/or evaluation regarding the sexual harm by youth. Addressing the ecological context of each youth in order to determine a process for

addressing the problematic behavior allows for a relevant and timely response. (Ryan, 2005; Gil & Johnson, 1993) This process requires specialized skill afforded by a QMHP with specialized training.

Evaluation Measures:

1. The program clearly states the qualifications for the QMHP consistent with recommendations in the standard.
2. The program clearly states the relevant ecological areas for triage to include, but not be limited to: safety; victim perspective and impact; family; education; recreation; social, economic, physical, and mental health; housing; and spirituality.
3. The program documents all contacts with victims when identified. Specific needs are identified to assist the victim in feeling safe from further harm.
4. The program identifies how it will facilitate access to community resources.
5. The program documents referrals for sexual health education and services.

4.) Assessment and Evaluation

Standard: When sexually harmful behavior is identified by a QMHP, a holistic evaluation process is conducted in order to inform treatment planning. Sexual-behavior-specific and comprehensive family systems assessments are vital parts of this process. This is an initial and ongoing process throughout the full continuum of care.

Rationale: The role of the QMHP is to develop treatment recommendations and determine a youth's ability to remain safely in the community. It is not the role of a QMHP to ascertain innocence or guilt of the sexual harm (Coffey, 2006).

Effective recommendations and implementation of treatment are dependent upon a comprehensive holistic evaluation (Prescott, 2006). It is important to distinguish between forensic assessment and treatment-related assessments. The focus of a forensic evaluation is legal and is not predicated upon a relationship with the youth. A treatment-related evaluation encompasses all elements identified in number 5 below.

Evaluation Measures:

1. The program documents that assessments are facilitated and documented by a QMHP with specialized training in work with youth who have caused sexual harm (licensed and/or credentialed in states where applicable).
2. The program documents that all evaluations are completed in a timely manner to facilitate treatment planning and implementation.
3. The program documents proof of family or social support network member participation in the assessment process, or barriers to it.
4. The program documents holistic evaluations based upon information obtained from a variety of sources. These include, but are not limited to:
 - Client
 - Victim
 - Client's Family
 - Victim's Family
 - Social Support Network
 - Court Records
 - Mental Health Records
 - Medical Records
 - School Records
 - Police Report
 - Previous Treatment and Evaluation Records

5. The program documents the following content in the holistic evaluation:
 - Individual and environmental strengths and resources
 - Review of background information and history
 - Developmental history and milestones
 - Sexual knowledge
 - Sexual history
 - History of sexually harmful behavior
 - History of non-sexual problematic or harmful behavior
 - Current sexually harmful situation
 - Youth's version of events regarding sexual harm
 - Victim's version of events regarding sexual harm
 - Dynamics of sexually harmful behavior
 - General psychological functioning
 - Educational and intellectual functioning
 - Ecological context (factors that address a youth's relationships and experiences with family, social support network members, peers, school, community activities, etc.)
 - Identification of any non-related persons who are seen as important to the youth (social support network)
 - Any history of trauma, abuse, and/or victimization of youth and family members
 - Internal and environmental protective factors
 - Static, stable, and dynamic risk factors of further sexual and non-sexual harm
 - Conclusions/recommendations
 6. The program documents continuous and ongoing assessment based on the developing strengths and needs of the youth and family (Henggeler, 1998).
 7. The program documents the assessment by a QMHP of victim needs for treatment and safety.
-

II. CLINICAL INTERVENTION STANDARDS

5.) Community Safety

Standard: A clear plan for immediate and long-term safety of victims, youth, and the community is established, based upon the degree of risk indicated in the comprehensive assessment. All service provision and treatment adhere to the established safety plan.

Rationale: The literature on sexual harm by youth often refers to safety as a guiding principle of treatment (Chaffin, Bonner, & Pierce, 2003; Hunter, 2004; Association for the Treatment of Sexual Abusers (ATSA), 2000; Schladale, 2006). Physical and emotional safety and stability are identified as a foundation for ethical treatment of children. (Stien & Kendall, 2004; Ferber, Pittman, with Marshall, 2002) A clearly defined safety plan provides a foundation for addressing strengths, needs, and risks in order to enhance successful treatment outcomes (Schladale, in press). If youth are placed in a treatment facility outside of their community (Szalavitz, 2006; Prescott, 2006) it is imperative that the facility be appropriately credentialed to provide services for the special needs of the youth as documented in Standards of Care for Youth in Sex Offense-Specific Residential Programs (Bengis, Brown, Freeman-Longo, Matsuda, Ross, Singer, & Thomas, 1999).

Evaluation Measures:

1. For each youth and family a plan for harm reduction will be developed and monitored.
2. All assessments document a detailed plan to address individual, family, and community safety. These include but are not limited to:
 - Goals of the safety plan
 - Specific behaviors to be enhanced
 - Specific behaviors to be stopped
 - All elements of the safety plan
 - Facilitators and participants involved and their roles in successful implementation of the safety plan
 - Rationale for choosing each facilitator and the role each facilitator will have in the process of the safety plan
 - Description of how each element of the plan reflects empirically driven practice
 - Decision making about implementation and review
 - Preparation time required to begin the safety plan
 - Materials needed for the safety plan and location of them
 - Process for addressing any challenges in the facilitation of the plan
 - Mediation plan in case of conflict between facilitators and participants
 - Time frame for the safety plan
 - Scheduled days and times participants will meet to assess the safety plan
 - Designated meeting facilitator, and substitutes
 - Protocol for starting each safety plan meeting
 - Measures used to determine the success of the plan
 - Designated responsibility for documentation of the safety plan
 - Documentation format
 - Document location
 - Designated information from each meeting that will help in the planning for the next safety plan assessment
 - Task assignment to ensure successful implementation of each phase of the safety plan (Schladale, in press)
3. When indicated, the program documents any victim input into safety plan development and implementation.
4. When indicated, the program provides any victim with information about the youth's placement status and documents release of such information.
5. Service provision is individualized and provided in the least restrictive manner with flexibility to meet the unique supervision needs of each youth.

6. The program provides written justification for increasing or decreasing the level of supervision and the level of restricted care.

6.) *Treatment Approach*

Standard: The program's central treatment approach is multidisciplinary and collaborative, delivered with the goal to eliminate harmful behavior and maximize human potential and happiness. Respect for victims, clients, and the community guides all aspects of treatment.

Rationale: Current evidence indicates that the most effective treatment is based upon a foundation of non-judgmental attitude, empathy, genuineness, and warmth (Hubble, Duncan, & Miller, 1999; Hunter & Chaffin, 2005).

Research indicates significant diversity among youth who have caused sexual harm (Hunter & Chaffin, 2005). Youth and families receive services from a variety of systems with an interest in the youth's success but with potentially conflicting agendas. A collaborative, multidisciplinary approach is necessary in order to meet the complex and myriad needs of the youth and family (Hunter & Chaffin, 2005). A youth's support by, and connection to, the community are critical to successful treatment outcomes. This approach requires access to and communication among service providers.

Evaluation Measures:

1. The program documents policy and procedures regarding delivery of a multidisciplinary approach.
2. The program documents the ongoing delivery of collaborative service provision.
3. The program documents adherence to all Health Information Portability and Accountability Act (HIPAA) guidelines.
4. The program documents all necessary release and exchange of information in accordance with HIPAA.
5. The program documents ongoing communication between relevant contacts across all domains of the youth and family's environment, including the victim when appropriate.
6. The program documents past and current service provision. Services may include but are not limited to physical and mental health, education, recreation, social and spiritual connections, and victim empathy education and training.
7. The program documents that a recipient rights statement has been provided to each client. Included in this statement is contact information regarding the process, should rights be violated.
8. The program uses client satisfaction surveys to document the client's experience of respectful service provision.
9. The program documents a grievance procedure for addressing client complaints.

7.) *Holistic Treatment*

Standard: All service provision is holistic in nature, addressing a youth's full ecological context relating to physical, social, psychological, and spiritual life domains. It focuses on strengths and needs to maximize potential for change in all areas of the youth and family's life.

Rationale: Successful treatment outcomes require holistic understanding of the complex nature of sexual harm by youth (Longo, 2002; Longo, 2004; Longo & Prescott, 2006; Morrison, 2006). Trajectories leading to problematic sexual behavior are multi-determined (Becker, 1998) and recidivism risk includes non-sexually harmful behavior (Borduin, 1990; Becker, 1990; Kahn & Chambers, 1991; Schram, Milloy & Rowe, 1991; Chaffin et al., 2003). Holistic treatment is not limited to behavioral modification of sexually harmful behavior. Approaching youth as multifaceted individuals addresses relevant needs that may seem peripheral to issues of sexual harm. Addressing these needs contributes to a youth's overall long-term success.

Evaluation Measures:

1. The program description documents provision of holistic treatment through attention to each youth's ecological context and all life domains.
2. Through an ecological assessment, the program documents strengths and needs in all life domains.
3. The program documents service delivery sensitive to individual, family, environmental, economic, educational, and cultural experience.
4. The program documents how treatment needs will be met and how strengths will be used to support treatment. When needs cannot be met within the scope of program services, documentation will include how, and who, will meet these needs.

8.) Individualized Treatment

Standard: Treatment is based upon the unique characteristics of each youth and family served. Strength-based individualized treatment with goals to eliminate sexual harm by youth includes, but is not limited to, competencies, strengths, sources of ecological support, needs, culture, and risks of each youth and family.

Rationale: Each youth and family has unique characteristics including unique experience of sexual harm by youth. Addressing such uniqueness is essential for achieving successful treatment outcomes (Hubble, Duncan, & Miller, 1999). Literature on sexual harm by youth indicates significant diversity among youth who cause sexual harm (Hunter, Figueroa, Malamuth, & Becker, 2003; Hunter & Chaffin, 2005). As a result each youth and family also requires individualized treatment (Hunter, Gilbertson, Vedros, & Morton, 2004; Center for Sex Offender Management, 1999).

Evaluation Measures:

1. Program documents identify individual characteristics (strengths, resources, social support, culture, and living environment) of each youth and family as a core component of evaluation, planning, and implementation of treatment.
2. The program documents an individualized treatment plan for each youth and family.
3. The program documents in the individualized treatment plan the process of goal setting for treatment, with involvement from the youth, family members, and significant others involved in the youth's life.

9.) Family Treatment

Standard: Family focus is central to a treatment process attempting to reduce sexual harm by youth. Family treatment involves dedication to actively engaging any available family members, or social support network members, throughout the full continuum of care. Such activity includes, but is not limited to: treatment planning; safety plan development and implementation; reconciliation; reunification; treatment team meetings; family therapy; daily care; and consistent emotional support and connection. When family of origin members are not available, kinship and extended network members are engaged.

Rationale: Therapeutic change occurs in the context of relationship. Family is central to life experience and always influences youth, regardless of where they live. Family history and relationships provide knowledge and understanding in the context of a youth's environment that is critical to successful treatment outcomes. Successful treatment outcomes are influenced by family members' participation in making needed changes and healing pain relating to sexually harmful behavior. Engaging families in treatment design and implementation holds the most promise for healing and harm reduction.

(Stroul & Friedman, 1986; Federation of Families for Children's Mental Health, 1995; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

Strategies for youth violence prevention involve parents and families, home visiting (Thornton et al., 2002), parent training, and marital and family therapy by clinical staff (Office of the Surgeon General, 2001).

Since some youth who have caused sexual harm have experienced trauma and abuse (Creeden, 2004; Creeden, 2006; Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Ryan & Lane, 1997), holistic treatment includes addressing childhood trauma. Best practices for child abuse treatment include trauma-focused and abuse-focused cognitive behavior therapy, and parent-child interaction therapy (Kauffman Foundation Best Practices Project, 2004).

Evaluation Measures:

1. The program documents a policy and protocol for ongoing family treatment.
2. The program documents family therapy in case notes.
3. When parents are not available, the program documents kinship and/or social support network member participation in therapy in case notes.
4. The program documents family involvement in treatment planning, as partners with the treatment team.
5. The program documents collaboration with professionals providing services to any family member who is a victim of the youth's sexually harmful behavior.

10.) Family Education, Support, and Respite

Standard: Family education, support, and respite are integral parts of community organization and collaboration.

Rationale: Stigma associated with sexual harm by youth is a significant barrier to engaging families in treatment (Schladale, 2006). Education of the youth and family relevant to sexual harm, therapeutic support, understanding, and connection have potential to reduce resistance and motivate compassionate change (Schladale, 2006). Support provides an avenue for addressing pain and considering options for healing. Families also need periodic respite from the intense experience of dealing with sexual harm by youth.

Evaluation Measures:

1. Programs document provision of education and educational resources for parents and families of youth who have caused sexual harm.
2. Programs document provision of support services through individual, family, and/or group processes.
3. Programs document provision of a trained, peer-led family support group.
4. Programs identify and document respite services.
5. When a youth's victim is a family member, the program documents provision of support services to the victim as well as the youth and the family as a whole.

11.) Treatment Components

Standard: Community-based treatment consists of a range of treatment components identified in current literature to address needs of youth and families. Individual needs and strengths of each youth and family determine which components are used in his or her treatment planning and implementation.

Rationale: Since recidivism rates of youth who have caused sexual harm indicate a higher risk of non-sexual delinquent behavior (Hunter, Gilbertson, Vedros, & Morton, 2004; Langstrom & Grann, 2000; Schram, Milloy, & Rowe, 1991;

Worling & Curwen, 2000), programs should make a concerted effort to adhere to the developing body of literature on youth violence prevention. Program development and maintenance should be consistent with evidence from resources such as *Youth Violence: A Report of the Surgeon General* (Office of the Surgeon General, 2001); *Blueprints for Violence Prevention* (Center for the Study and Prevention of Violence, 2006); and *Best Practices of Youth Violence Prevention: A Sourcebook for Community Action* (Thornton, et al., [Center for Disease Control], 2002). These sources indicate a need for multi-modal treatment utilizing parent- and family-based, home-visiting, social-cognitive, and mentoring strategies.

Research studies identify elements of life experience that influence risk and protective factors for recidivism of sexually harmful behavior (Ryan & Lane, 1997; Bremer, 2006; Prentky & Righthand, 2003; Epperson, Ralston, Fowers, Dewitt, & Gore, 2006; Prescott, 2006).

Youth who have caused sexual harm often come from backgrounds reflecting significant trauma (Schladale, 2006; Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Creeden, 2004; Creeden, 2006; McMackin, Leisen, Cusack, LaFratta, & Litwin, 2002). It is therefore imperative that interventions reflect evidence-based practices for responding to child abuse and trauma (Kauffman Foundation Best Practices Project, 2004).

Youth mentoring is an important component of holistic service provision for youth who have caused sexual harm. All youth need positive role models for optimum development (Ferber et al., 2002). Evidence-based research indicates that youth mentoring is a strategy critical for youth violence prevention (Thornton et al., 2002; Center for the Study and Prevention of Violence, 2006).

Literature addressing elements relating to sexual harm by youth identifies the components of treatment listed below (Hunter et al., 2000; Center for Sex Offender Management, 1999; Schladale, 2006; Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Creeden, 2004; Creeden, 2006; McMackin, Leisen, Cusack, LaFratta, & Litwin, 2002; Kauffman Foundation Best Practices Project, 2004; Schore, 2003).

These components of treatment occur in a holistic, ecological framework throughout the full continuum of care. Utilizing a family focus that addresses physical, social, psychological, and spiritual elements of therapeutic change enhances potential for long-term successful outcomes.

- Eliminating harmful behavior
- Teaching affect regulation (Schore, 2003; Stien & Kendall, 2004; Groves, 2002)
- Teaching social problem solving, including resolving interpersonal disputes (Office of the Surgeon General, 2001; Thornton et al., 2002; Henderson, 1996)
- Building social skills to enhance greater self-confidence and social competency (Office of the Surgeon General, 2001; Thornton et al., 2002)
- Promoting social perspective taking to enhance empathy for and sensitivity to the negative impact of sexual harm on victims, families, and communities (Office of the Surgeon General, 2001)
- Mentoring youth (Ferber et al., 2002; Thornton et al., 2002; Center for the Study and Prevention of Violence, 2006)
- Helping youth to understand and intervene in patterns of triggers, thoughts, and feelings that may influence sexually harmful behavior (Hunter et al., 2000; Center for Sex Offender Management, 1999)
- Promoting positive self-worth and self-confidence (Henderson et al., 1996; Ferber, Pittman, with Marshall, 2002)
- Developing an appreciation for and connection to one's culture (Hunter et al., 2000; Center for Sex Offender Management, 1999)
- Clarifying and modeling values related to respect for self and others (Henderson et al., 1996)
- Teaching and modeling social psychology of gender as a component of harm reduction (Burn, 1996).
- Teaching sexual health (Hunter et al., 2000; Center for Sex Offender Management, 1999; Brown & Schwartz, 2006; Ryan & Lane, 1997)

- Healing trauma (Schladale, 2006; Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Creeden, 2004; Creeden, 2006; McMackin, Leisen, Cusack, LaFratta, & Litwin, 2002; Kauffman Best Practices Report, 2004; Schore, 2003)

Evaluation Measures:

1. Consistent with current literature, the program documents, in detail, all components of treatment and the rationale for their inclusion.

12.) Treatment Modalities

Standard: Evidence-based practice, addressing the strengths and needs of each youth and family, guides the use of specific treatment modalities.

Rationale: Current literature indicates the use of a multimodal approach for responding to sexual harm by youth (Center for Sex Offender Management, 1999). Choice of treatment modality, resulting in effective treatment, is informed by knowledge of current research findings. There is a need for careful consideration of content and composition for each treatment modality. Treatment fidelity should be monitored with every evidence-based practice.

There is simply not enough empirical evidence at this time to state definitively that any single treatment modality is superior. It is therefore imperative that treatment planning focus upon the unique needs of each youth in the context of his or her family and community supports.

According to recent investigation, parent-family and home-based strategies provide the most promising approaches to youth violence prevention, including sexual harm by youth (Thornton et al., 2002, Henggeler et al., 1998). The Office of the Surgeon General's report on youth violence prevention indicates that individual therapy is ineffective (2001). While group therapy has previously been identified as the recommended modality for responding to youthful sexual aggression (National Adolescent Perpetrator Network, 1988, 1993), such recommendations are based upon conventional wisdom and are not supported by empirical evidence (Chaffin & Bonner, 1998). As controversial as these findings may be, the field of youth sexual offender treatment has suffered as a result of building treatment programs on modalities of treatment for which there is inconclusive evidence. Choosing to work in a non-multimodal approach limits the effectiveness of treatment.

Evaluation Measures:

1. The program documents a description of services that includes but is not limited to detailed information about treatment modalities, evidence-based references, and theoretical underpinnings supporting the chosen modalities.
2. Upon request, the program can articulate the research basis for any and all services provided for youth and families.
3. The program documents policies and procedures for each treatment modality.
4. The program monitors and documents treatment fidelity throughout the course of service provision.

13.) Treatment Plan

Standard: Treatment plans are holistic, family focused, assessment driven, goal oriented, comprehensive, and individualized for each youth and family. A comprehensive treatment plan is developed with the youth and family to identify their strengths, resources, and goals. Treatment plans are continuously evolving documents designed to monitor progress and/or

goal achievement in order to determine service completion.

Rationale: Goal-oriented treatment plans guide a process of treatment and benefit all involved parties: youth, family, treatment providers, funding sources, and communities (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Progress and outcomes are reflected in the treatment plan. Changes are made as circumstances dictate. Services are completed as outcomes are achieved.

Evaluation Measures:

1. The program documents, in a timely manner, a treatment plan identifying goals of the youth and family using the youth's and family's own words. The time frame is defined by agency policy or regulatory standards.
 2. The original treatment plan documents clear and measurable goals and objectives for goal attainment and progress towards service completion.
 3. The treatment plan will be reviewed and updated with the youth and family in accordance with agency policy or regulatory standards. Such reviews and updates will take into consideration the original goals and objectives, changes in needs and strengths, documentation of progress or lack thereof, and/or requests from the youth and/or family for modification.
 4. The treatment plan documents the decision and rationale for completion of services.
 5. The initial treatment plan and all reviews will be signed by the youth, family and involved stakeholders.
-

III. COMMUNITY RESPONSE STANDARDS

14.) Community Organization and Collaboration

Standard: All public and private agencies serving youth use an integrated and coordinated approach for responding to sexual harm by youth.

Rationale: Correlates of sexual harm by youth indicate a complex and multidetermined pathway to offending. (Becker, 1998; Evans, Dollard, & McNulty, 1992; Prange, Greenbaum, Silver, Friedman, Kutash, & Duchnowski, 1991; Quinn & Epstein, 1998) Such complexity involves multiple service providers. A comprehensive response requires community organization and collaboration of all stakeholders across all systems of care (Burns & Hoagwood, 2002). Gaps and overlaps in service are identified and addressed more effectively through a process of sharing ideas and resources guided by empirically driven research.

Evidence-based literature cites a need to identify committed advocates and key messengers to provide leadership that enhances community efforts to address child abuse (Kauffman Foundation Best Practices Project, 2004).

Evaluation Measures:

1. Community stakeholders document designated methods for collaboration, communication, and oversight of the coordinated process for responding to sexual harm by youth.
2. Communities will have identified committed advocates and key messengers to ensure a collaborative, evidence-based response to sexual harm by youth.
3. The community team includes, and documents membership of, at least one victim advocate who has experience in working with victims of sexually harmful behavior.
4. Community stakeholders identify and document gaps and overlaps in service and create action plans for correction.

15.) Uniform Response Protocol

Standard: A single point of entry for service delivery is optimal for treatment consistency. Uniformity in the referral process ensures that all youth will have equal and timely access to available services.

Rationale: All youth who have exhibited sexually harmful behavior deserve access to the same array of services regardless of potentially discriminatory factors such as race, gender, socioeconomic status, physical, emotional, mental, and intellectual disabilities; education; religion; sexual identity; and insurance coverage. “The purpose of the [single point of entry] SPOA for children and families is to identify those children with the highest risk of placement in out of home settings and to develop appropriate strategies to manage those children in their home communities.” (New York State Office of Mental Health, 2006) A single point of entry enhances streamlined service provision and identifies gaps in resources.

Evaluation Measures:

1. A community team is created and responsible for developing and monitoring this access process.
2. The community team documents training for service providers (i.e., law enforcement, social services, the court, education, etc.) to make them aware of the process for notifying the community team of youth who have been identified with sexually harmful behavior.
3. The program documents access to service provision based upon a comprehensive and objective referral process.

16.) *Community Education*

Standard: Committed advocates and key messengers educate community members about evidence-based practices for responding to sexual harm by youth. Promoting widespread support for these youth's success in the community can effect harm reduction.

Rationale: Successful treatment outcomes depend upon informed and knowledgeable collaborative community efforts (National Adolescent Perpetrator Network, 1993; Center for Sex Offender Management, 1999). All persons involved with youth should be educated to recognize indicators of sexual harm and how best to respond. Professionals specializing in treatment of sexual harm by youth are obligated to provide youth and families with current evidence-based practice. Educating the families and the communities regarding current evidence-based practice is also an important part of their role.

Evaluation Measures:

1. Stakeholders identify and collaborate with key messengers for community education regarding sexual harm by youth.
2. Stakeholders create and document a plan for community education that encompasses primary, secondary, and tertiary prevention.
3. The program documents any involvement in community education.

17.) *Community Supervision and Surveillance*

Standard: Collaboration among youth, families, social support network members, and designated youth justice and social service entities, when indicated, provides supervision and surveillance.

Rationale: In order to remain in the community, youth who have caused sexual harm require supervision. Research indicates that most youth who cause sexual harm can be safely managed in the community (Association for the Treatment of Sexual Abusers, 2000; Chaffin, Bonner, & Pierce, 2003). Parents and other informal supports provide the primary source of supervision. When a higher level of security is indicated, community safety can be maintained through an organized network of formal and informal supports and/or court-ordered surveillance. To ensure community safety, designated officers of the court provide supervision and surveillance (when indicated) for youth under supervision of the court (Center for Sex Offender Management, 1999; Hunter & Chaffin, 2005). "...Supervision typically prove[s] useful in ensuring client accountability and compliance with treatment as well as a means to prevent future victimization" (Center for Sex Offender Management, 1999, p. 7).

Evaluation Measures:

1. The program will have a documented safety plan for each youth and family receiving services included in the case record.
2. When indicated, the program documents victim involvement in development of the youth's safety plan.
3. The program documents in the safety plan that supervision and/or surveillance are provided in accordance with the agreed-upon level of need in order to maintain community safety.
4. The safety plan documents that when supervision and/or surveillance are indicated, officers of the youth court provide such service, having received specialized training for responding to sexual harm by youth.
5. The program documents, in case notes, efforts to collaborate with officers of the court who provide supervision and/or surveillance.

IV. PROGRAM-RELATED STANDARDS

18.) Empirically Driven Practices

Standard: Programs serving youth employ staff members who have the knowledge, ability, and commitment to provide empirically driven responses to sexually harmful behavior.

Rationale: Programs providing screening, assessment, and treatment for youth who have caused sexual harm and their families, have a responsibility to provide treatment in the most efficacious and cost-effective manner based upon pertinent research evidence.

Empirically driven research reflects scientific efforts to establish evidence-based practices. For the purpose of these standards, empirically driven refers to a commitment to provide the most efficacious services based upon rigorous scientific inquiry.

Evidence-based practice (EBP) is a relatively new term used to address an emerging field of research concerning the effectiveness of a designated method or practice. The highest level of evidence-based research is supported by multiple, controlled, randomized outcomes studies. Chaffin (2006) defines evidence-based practices as “the competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)” (p. 661). There are few evidence-based practices in the field of juvenile sexual offending (Henggeler et al., 1998).

Treatment fidelity is required with evidence-based practices (Chaffin, 2006; Thornton, Craft, Dahlberg, Lynch, & Baer, 2002).

When a program does not employ staff with the knowledge and ability to provide specialized services, it has an ethical responsibility to refer to or obtain qualified service provision.

Evaluation Measure:

1. The program documents a treatment approach reflecting empirically driven research that provides a rationale and foundation for all components of treatment.
2. For any evidence-based practices, treatment fidelity is monitored and documented throughout the full course of service provision.
3. The program requires and documents all staff development and training on empirically driven interventions.
4. The program documents evaluation of staff knowledge, skills, and ability to implement empirically driven treatment.
5. When the program cannot provide specialized services, it documents referral to qualified service providers.

19.) Continuum of Care with Seamless Transition

Standard: All services are designed and maintained to facilitate seamless transitions, across a full continuum of care, with a continuity of service providers. Regardless of where a youth resides, a designated member of the treatment team, in accordance with youth and family needs and community protocol, coordinates service provision.

Rationale: All youth who have caused sexual harm need access to a range of treatment options in order to provide a unified treatment approach across a variety of settings. A continuum of care offers options for least restrictive treatment settings, consistent with the needs of each youth, family, and community (Bengis et al., 1999; Longo & Prescott, 2006).

When a youth’s position in the continuum of care involves out-of-home-placement, community services continue for the family. Collaboration and coordination involves formal and informal communication among the youth, family, and out-of-

home and community-based service providers.

When reconciliation has occurred and reunification is indicated, the family and the community are prepared to support the youth's return (Report of the New York Statewide Workgroup on Youth and Adolescent Sexual Abusers, 1999; Schladale, in press).

Evaluation Measures:

1. The program has a directory of qualified service providers and locally available licensed QMHPs (credentialed in states where applicable).
2. The program documents and enforces use of a protocol for accessing services in the least restrictive setting across the full continuum of care. This takes place through the uniform response protocol.
3. The program documents knowledge of and access to a community team that monitors access to a full continuum of services.
4. The program documents a rationale for the choice of service provision for each youth and family served.
5. The program documents all transitions and rationales for timely change in service along the continuum of care.
6. The program documents collaboration and coordination between community-based and out-of-home service providers.
7. The program documents what services along the continuum of care it provides.
8. The program documents access to and/or representation on the community team.

20.) Cultural Sensitivity

Standard: All services are provided with respect for human diversity and the cultural uniqueness of all families. Support is provided with sensitivity to gender, race, ethnicity, nationality, sexual identity and orientation, disabilities, religion, culture, and socioeconomic status.

Rationale: Human interaction is best understood within its environmental context (Bronfenbrenner, 1977, 1979). Behavior has accurate meaning when understood from the perspective of the culture from which it derives (Cole, 1998). With sensitivity to the culture of each youth and family, it is possible to understand patterns of behavior.

Evaluation Measures:

1. The program has and institutes a documented policy for equal access to services.
2. The program has and institutes a documented policy for training staff on cultural diversity.
3. Personnel files document staff participation in training on cultural sensitivity.
4. The program documents current evidence-based curricula for staff development and continuing education specific to cultural sensitivity.

21.) Restorative Justice

Standard: Services are provided within a context of restorative justice.

Rationale: "Restorative justice and community justice represent new ways of thinking about crime" (Kurki, 1999). While research indicates that the majority of youth who have caused sexual harm can be adequately served in their home communities (Association for the Treatment of Sexual Abusers, 2000), residential placement for these youth proliferated during the late twentieth century (Puzzanchera, 2000).

Restorative justice attempts to address accountability and consequences through a victim sensitive approach with a goal of community healing. While it was created in the context of criminal justice, it does not require involvement with the criminal justice system. Youth can be presented with opportunities to take responsibility for sexually harmful behavior and make amends to their victims, families, and community regardless of court involvement.

Restorative justice is based upon principles that guide a reparative process in response to criminal behavior. Howard Zehr defines restorative justice as "... a process to involve, to the extent possible those who have a stake in a specific offense and to collectively identify and address harms, needs, and obligations, in order to heal and put things as right as possible" (2002, p. 37). Restorative justice acknowledges that crime harms relationships. Goals of programs based upon restorative justice principles should include:

- Identifying and addressing needs of victims
- Offender accountability
- Competency development for the offender
- Community safety (Zehr, 2002)

Evaluation Measures:

1. The program description defines and describes the program's restorative justice practices.
 2. When requested by victims and appropriate for the youth, the program provides and documents participation in a facilitative dialogue to promote healing for the victim.
 3. The program has documented policies and procedures to implement restorative justice practices.
 4. The program documents training for all staff involved in the facilitation of restorative justice practices.
 5. The program documents restorative justice practices in each client's case file as they are facilitated and completed.
 6. The program documents collaboration with the victim's treatment providers when considering restorative practices that involve the victim.
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V. SERVICE PROVIDER STANDARDS

22.) *Specialized Training for Responding to Sexual Harm by Youth*

Standard: Specialized training with evaluative supervision for responding to sexual harm by youth is necessary for professionals at all levels of service provision.

Rationale: Specialized training for service providers is necessary to reduce sexual harm (Hunter & Chaffin, 2005; Bengis et al., 1999). Communities are better protected when service providers are specially trained. Where available, service providers have an obligation to meet statutory requirements for certification, or licensure, relating to sexual harm by youth.

Evaluation Measure:

1. The program documents in all personnel files specialized training and applicable credentials for responding to sexual harm by youth.

23.) *Staff Qualifications and Competence*

Standard: Program employs staff members who are qualified and competent to work with youth who have caused sexual harm.

Rationale: Interventions for youth who have caused sexual harm require a broad foundation of expertise. All staff working with this population are responsible for demonstrating competency in providing a therapeutic response to youth who have caused sexual harm (Bengis et al., 1999).

Evaluation Measures:

1. The program has written job descriptions that identify personal and professional qualifications necessary for satisfactory job performance in working with youth who have caused sexual harm.
2. The program documents criteria for hiring.
3. The program documents results of background checks of child abuse and criminal records in all personnel files.
4. The program documents in personnel files successful completion of educational requirements for employment and applicable licensure.
5. The program documents in personnel files successful completion of specialized training, applicable credentials, and continuing education for addressing sexual harm by youth.
6. The program documents policies and procedures identifying staff responsibilities, support, supervision, and channels of communication.

24.) *Staff Supervision*

Standard: All staff participate in timely and regular face-to-face supervision, either individual or group, specific to youth who have caused sexual harm that includes personal and interpersonal impact on the service provider. Crisis supervision is available as needed.

Rationale: The purpose of staff supervision is to provide a supportive, safe, and non-threatening environment for addressing issues relevant to the needs of the identified youth. Due to the intense nature of this work, supervision is essential for responding to youth who have caused sexual harm.

Evaluation Measures:

1. The program employs staff qualified to provide supervision regarding sexual harm by youth.
2. When the program does not employ a qualified supervisor, it contracts with a qualified outside supervisor.
3. The program documents that supervisors have a minimum of two years of supervised practice with this population.
4. The program documents supervision specific to sexual harm by youth, including opportunities to discuss the personal/interpersonal impact of the work on the service provider. The frequency of supervision is determined by documented experience and demonstrated skills of each staff person.
5. The program documents specific feedback and information regarding interventions, techniques, and methods addressed in clinical supervision.
6. Administrative supervision assures that caseload is consistent with the demands of the cases and allows for the provision of services as needed by the youth and family.

25.) Therapist

Standard: A youth and family's primary therapist will hold a master's degree or doctorate from an accredited program in a mental health field. In addition, the therapist will have successfully completed specialized training and demonstrated competency for responding to youth who have caused sexual harm (credentialed in states where applicable).

Rationale: Treatment of youth who have caused sexual harm is a specialized field (Bengis et al., 1999; Colorado Sex Offender Management Board, 2003; Hunter & Chaffin, 2005). Therapists who treat this population must be qualified and competent to meet the needs of these youth and their families.

Evaluation Measures:

1. The program documents, in therapist's personnel files, successful completion of an advanced academic degree in a mental health field from an accredited program and any applicable clinical licensure.
2. The program documents, in therapist's personnel files, successful completion of specialized training addressing treatment for youth who have caused sexual harm and any applicable credentials.
3. The program has documented job descriptions that identify personal and professional qualifications necessary for satisfactory job performance for working with youth who have caused sexual harm.
4. The program documents criteria for hiring. It documents results of background checks of child abuse and criminal records in all personnel files.

26.) Therapist Supervision

Standard: All therapists participate in timely and regular supervision specific to sexual harm by youth. Crisis supervision is available as needed.

Rationale: The purpose of clinical supervision is to provide a supportive, safe, and non-threatening environment to address clinical and personal issues and monitor treatment fidelity (Henggeler et al., 1998). Due to the intense nature of this work, clinical supervision is essential for responding to sexual harm by youth.

Evaluation Measures:

1. The program employs staff qualified to provide clinical supervision regarding sexual harm by youth. When the program does not employ a qualified clinical supervisor, the program contracts with a qualified outside clinical supervisor.
2. The program documents that clinical supervisors have a minimum of two years of supervised practice with this population.
3. The program documents clinical face-to-face supervision specific to sexual harm by youth. The frequency of supervision is determined by documented experience and demonstrated skills of each therapist.
4. The program documents specific feedback and information regarding treatment interventions, techniques and methods, and personal/interpersonal impact on the therapist, addressed in clinical supervision.
5. The program documents clinical supervisor input for the therapist performance review.

27.) Continuing Education

Standard: All staff responding to youth who have caused sexual harm will participate in specialized continuing education on a regular basis to ensure knowledge of current research, theory, and practice.

Rationale: The field of sexual harm by youth is just beginning to identify evidence-based treatment approaches that inform intervention (Chaffin, 2006). Research in the field continues to influence significant change in service provision (Longo & Prescott, 2006; Prescott, 2006). In order to assure competence in the implementation of safe and effective treatment processes, it is imperative that all staff participate in specialized continuing education (Hunter & Chaffin, 2005).

Evaluation Measures:

1. The program documents and implements a written plan for training all staff on topics specific to sexual harm by youth.
 2. The program has written policies and procedures providing annual release time for staff to attend local, state, and national workshops and conferences specific to sexual harm by youth.
 3. The program monitors and documents each staff member to ensure completion of training required by programs and applicable professional licensure board.
 4. Certificates of attendance for all continuing education are current, and maintained in each personnel file.
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GLOSSARY

Because there is a range of potential interpretations, the following operational definitions are provided:

Affect Regulation: A person's ability to manage emotions so as not to cause harm (Schoe, 2003).

Assessment: An ongoing process that involves face-to-face interviews with, and observations of, youth and family members, for the purpose of collecting information relevant for treatment planning. Objective measures, when available, should be included.

Barriers: Anything that impedes progress toward, or completion of, established treatment goals.

Best Practices: Treatment techniques, procedures, and protocols that have been established and described in some detail. Effectiveness of these practices has been acknowledged through consensus among experts in the field. Key portions of these practices may have been documented in research studies to be effective in selected treatment settings.

Certification: Documentation of successful completion of specialized, evaluative training demonstrating knowledge, skills, competency, and experience in addressing sexual harm by youth.

Collaboration: A process of working together to forge partnerships for developing common goals, sharing information, creating compatible internal policies to support those goals, joining forces to analyze problems, and creating responsible solutions that are empirically driven and cost-effective.

Committed Advocates: "Determined and vocal advocates from the ranks of consumers and interested parties who accelerate the pace of spread of innovation in health services" (Kauffman Foundation Best Practices Project, 2004, p. 31).

Community: The ecological structure in which a youth lives.

Community-Based: Services and resources provided in a youth's home and community in order to minimize disruption of the youth's daily living and provide participation by the youth's family and social support network.

Competency: Established criteria for adequate education, training, experience, and skills required to perform a specific task.

Continuum of Care: A broad range of interventions allowing service delivery to best meet a youth and family's needs in the least restrictive manner, based upon an initial holistic evaluation and ongoing assessment.

Core Values: Essential and enduring tenets of an organization, task force, or group of individuals united by a common purpose or goal. These core values are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those individuals within the organization, task force, or work group (CARF: The Rehabilitation Accreditation Commission, 2001).

Culture: Personal attributes and characteristics socially and biologically acquired; encompassing but not limited to gender, race, ethnicity, sexual orientation, religion, nationality, and financial status.

Ecology: Relationships between a youth and his or her physical and social environments.

Empirically Driven: An effort to integrate scientifically based studies into practice.

Evaluation: A comprehensive review and accumulation of information regarding a specific youth. Holistic evaluation includes all areas of a youth's life and includes a sexual behavior-specific assessment.

Evidence-Based Practices: “The competent and high-fidelity implementation of practices that have been demonstrated safe and effective, usually in randomized controlled trials (RCTs)” (Chaffin, 2006, p. 661).

Family: “Two or more persons who share resources, share responsibility for decisions, share values and goals, and have commitments to one another over time. The family is that climate that one ‘comes home to,’ and it is this network of sharing and commitments that most accurately describes the family unit, regardless of blood, legal ties, adoption or marriage” (American Home Economics Association as cited in Friedan, 1981, p. 78). This may include other family or social support network members not previously involved in the youth’s life.

Family Therapy: A modality of treatment in which the interrelationships of family members are examined in order to identify and alleviate problems of one or more family members. Family therapy may include any individual who has an important connection to the youth, regardless of blood or legal ties.

Forensic Evaluation: An evaluation designed to assist the legal system in the decision-making process. It is objective and is not predicated upon a relationship with the youth (Coffey, 2006).

Harm Reduction: A preventive, health-promoting perspective that explores patterns of adaptation and competence for youth learning to manage their lives in ways that will no longer cause harm (Laursen & Brasler, 2002).

Holistic: Emphasizing the importance of an integrated whole and the interdependence of its parts.

Individualized Treatment: All services are flexible and based upon the unique individual strengths and needs of each youth and family.

Individual Therapy: Therapy that is prescriptive and provided by a specially trained and credentialed therapist. It is used as a forum for addressing personal victimization, co-occurrence and complicated family issues and for providing crisis intervention. It can also be used to address treatment compliance issues and reinforce didactic material presented in group therapy (Hunter et al., 2004).

Key Messengers: “Leaders within professional organizations who become outspoken advocates for the adoption of [empirically driven] best practices” (Kauffman Foundation Best Practices Project, 2004, p. 32).

Multi-Modal: A term used to describe a combination of treatment modalities to include multidisciplinary meetings; individual, group, and family therapy; and psychoeducation.

Program: Any clinical entity providing home- and/or community-based service to these youth and families.

Qualified Mental Health Provider: An individual who holds a master’s degree or doctorate from an accredited program in a mental health field. This person adheres to all licensure/certification requirements that are mandated by the state where services are being provided. Nationally, QMHPs are generally considered to be psychiatrists, psychologists, social workers, marriage and family therapists, mental health counselors, and clinical nurse specialists.

Restorative Justice: A process to involve, to the extent possible, those who have a stake in a specific offense and to collectively identify and address harms, needs, and obligations in order to heal and put things as right as possible (Zehr, 2002).

Risk Assessment: A process of classifying or categorizing individuals according to indications of likelihood of engaging in future harmful behavior. This is done on the basis of subjective clinical impressions, objective actuarial methods, and valid reliable risk assessment instruments (Chaffin, Bonner, & Pierce, 2003).

Sexual Harm by Youth: Any sexual act that is hurtful to another individual or any sexual act that is defined as illegal by the criminal statutes of the jurisdiction in which the behavior occurred (Chaffin, Bonner, & Pierce, 2003).

Social-Cognitive Interventions: Therapeutic techniques that focus on changing thinking and interactional patterns of behavior. Such interventions “strive to equip children with the skills they need to deal effectively with difficult social situations” (Bandura, 1985, p. 119). Social-cognitive interventions incorporate didactic teaching, modeling, and role-playing to enhance positive social interactions, teach non-violent methods for resolving conflict, and establish or strengthen non-violent beliefs in young people (Thornton et al., 2002; Office of the Surgeon General, 2001).

Social Support Network: Any non-related persons who are seen as important to the youth and are assessed to provide positive role modeling.

Specialized Training: An educational process, based upon empirically driven practices, focusing on sexual harm by youth that prepares all service providers to respond competently to the special needs of these youth and families.

Staff: Employees who deliver services to youth and families in conjunction with therapists and/or other involved QMHP.

Stakeholders: Individuals or groups with an interest in the activities and outcomes of an organization and its programs and services. They include, but are not limited to, the persons served, families, governance or designated authority, referral sources, personnel, employers, advocacy groups, contributors, supporters, business interests, and the community (CARF: The Rehabilitation Accreditation Commission, 2001).

Systems of Care: All professional, public, and private entities brought together to serve youth and families in an organized, integrated manner.

Therapist: Any qualified mental health professional licensed to provide psychotherapy. This generally includes psychiatrists, psychologists, marriage and family therapists, social workers, clinical nurse specialists, and mental health counselors.

Treatment Fidelity: The process of adhering to an evidence-based intervention or approach to therapy that monitors compliance with all components of the model to ensure successful outcomes.

Youth: Any person under the age of 18 or 21, depending on legal age as defined by state statute, for which services are being provided.

Wraparound: A collaborative, strengths-based model of family- and community-centered practice anchored in ecological and systems theory (Malysiak, 1997). The process is designed to bring social support network members of a youth and family together for the purpose of keeping the youth within the family system.

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