Cliff Notes: Juveniles with Sexually Harmful Behaviors

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It all starts with

The Assessment

Assessments are:

- Assessments are only as good as the information gathered during the interview and record reviews.
- Assessments are ongoing - they are never static! If anything changes; Risk – Need – Responsivity, living space, school, development, family, etc. the assessment should be updated to reflect the changes.
- No matter what, the assessment is only good for 6 months

Assessment Are To

- Inform decisions about the adolescent's care and treatment
- Inform on adolescent's risk, needs, and responsivity factors
- Reviews both sexual and general delinquency risk factors
- Determine adolescent's risk relevant intervention strategies and provide information on factors impacting responses to treatment
- Determine when and if needed more intensive services, no specialized services warranted, or for when services are no longer warranted

R-N-R Review

- Risk = factors within the adolescent's environment associated with sexual and/or general abusive behaviors. Treatment should match risk.
- Need = what will reduce the adolescent's risk for sexual or general abusive behaviors? What should be the treatment target?
- Responsivity = effective methods to maximize the adolescent's and his/her family's ability to benefit and learn from rehabilitative interventions; tailored to the individual

ATSA Adolescent Practice Guidelines are based in the empirical framework of the Risk – Need – Responsivity Principles

- How do we go about finding risk?
  - Appropriate assessment = youth's need for structure, supervision, and treatment
- Needs are what?
  - Adolescent's or family dynamic factors (identified in the assessment initially) that can reduce the adolescent's risk for sexual or general reoffending
- Responsivity
  - Effective methods to maximize the adolescent's and family to benefit from treatment and rehabilitative interventions based on what we learn from assessment on risk

*** Note RNR is an adult model, focused on criminal risks ***

Thoughts for Risk

- Need to look at both nonsexual and sexual risk – as we have learned more likely to commit a nonsexual crime than sexual crime in the future.
- Need to understand protective and risk related factors – to best provide recommendations based on needs and responsivity
- Responsivity needs to be driven individually to the youth
- Risk factors are dynamic….They can change! Numbers do not matter
- What does the current research say?

Research says

- Caldwell (2016)
  - Quantifying the Decline in Juvenile Sexual Recidivism Rates
  - 33 Studies (2000-2014)
  - 106 Data Sets
  - 20,008 Juvenile Offenders

Hope

- Calculated sexual recidivism rate at 2.75%
  - Regardless of the intervention

Risk Assessment are

Appropriate for	Not Appropriate for
• Sexual risk assessment for youth ages over 12 years old and youth involved with the juvenile or CHINS legal system	• Assessment for youth ***under 12*** years old who engaged in sexually reactive behavior, risky to self, or harmful behaviors

When to do the Assessment

The preferred practice to complete the Risk Assessment is post-adjudication; however, there are situations that warrant consideration of a pre-adjudication assessment, such as:

- All the legal professionals involved in the case are seeking information to assist in formulating a plea agreement or to support moving a plea agreement forward.
- The judge is seeking additional information prior to accepting to a proposed plea agreement.
- The court is withholding the charge, providing the adolescent an opportunity for treatment, resulting in no formal action on the offense.
- Diversion Cases

What sexual behaviors are we assessing?

- "Common/Healthy" -- Problematic -- Harmful
  - ALL of them
- How do we define the behavior?
  - How does the youth define behavior
  - How does the caregiver define the behavior
- How does trauma impact the sexual behaviors exhibited by youth?

Assessments Gather

- Multiple reliable sources of information
- Interviews of youth and caregiver/s
- Information from professional sources ie. School, probation, courts, previous treatment providers
- RNR at that time – as we know these factors change and the adolescent is in a development life stage – therefore we are only speaking of RNR at the time of the assessment
- Assessments should be repeated as an adolescent progresses through treatment, if any major changes happen in home or life, and to determine if youth is ready for discharge.

Assessor – who has it in them?

What should an assessor possess?

- Grounding – engaging demeanor
- Practice within your practice scope – Psychology vs Social work degrees
- Knowledgeable on youth's development on all areas
- Knowledgeable on the range of youth's sexual behaviors
- Unbiased, sensitive, and impartial interviewing skills
- Understanding each youth is different, every time, all the time

Assessment Report Should Include, but not limited to the following

- Confidentiality – Limitations
- Family Domain
- Developmental History
- Problematic and Abusive Sexual Behaviors
- Home Environment
- Social and Community
- Risk and Needs Measure
- R – N – R
- Recommendations
- What are your most important things to ask/include in an assessment?

Assessment Domains – Sexual Contacts/ Problematic Behaviors/Abusive Behaviors

- Make sure youth and evaluator are on same page of definition for sexual terms
- Sexual History
  - Contact vs. Non-contact
  - Girlfriends vs. sexual encounters
- Pornography – Naked Pictures
- Technology for sexual purposes
  - Omegle, Sexting, Tik Tok, Snapchat, other apps?
- Masturbation
- Sexual Behaviors with animals
- Fantasies
- Documented offense
  - Youth's version
  - Attitude to include sexual attitude regarding offense

Assessment Measures - Polygraphs

- In 2017, ATSA published the *Practice Guidelines for Assessment, Treatment and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior*. The *Practice Guidelines* provide guidance to practitioners and others who work with adolescents who have sexually abused or are at risk to abuse.
- **ATSA Practice Guideline Regarding the Use of Polygraph**
  - The *Adolescent Practice Guidelines* recommend **against the use** of polygraph with juveniles.

Assessment Measures - Polygraph - Implications for Practice

- ATSA members state commitment to guidelines, but guidelines do not necessarily reflect or replace local and/or applicable statutes, provisions, requirements, and other standards that may govern or shape practice
- The *Guidelines* require practitioners "to take steps to achieve an appropriate resolution in cases where a conflict between these guidelines and legal and professional obligations occur."

AUC Review on Assessment Measures

Hanson & Morton-Bourgon, 2009 *Psychological Assessment, 21,* 1-21

Meta-analysis of risk assessment accuracy

All actuarial tests

81 studies

24,089 males (primarily ADULT)

average **AUC=.68** (*d*=.67)

Static-99

63 studies

20,010 males (primarily ADULT)

average **AUC=.68** (*d*=.67)

Miccio-Fonseca, 2013 (Journal of Family Violence, 28, 623-634.)= AUC=.71 (95% CI .62-.80)

Slides by Worling, 2018

Viljoen, Mordell, & Beneteau (2012) *Law and Human Behavior*

Risk Measure (# of studies)	AUC (sexual recidivism)	
	Judgment (95% CI)	Total Score (95% CI)
J-SOAP-II (9)	n/a	.67 (.59-.75)
J-SORRAT-II (7)	n/a	.64 (.54-.74)
ERASOR (10)	.66 (.60-.71)	.66 (.61-.72)
Heterogeneity (Q) significant for all tools		

Rasmussen, 2018 (International Journal of Offender Therapy and Comparative Criminology, 62, 2937-2953.) = AUC=.67 (95% CI .52-.82)

Risk and Needs Assessment Measures

- Unstructured clinical judgement = best guess?
- Adding a tool or two tools = identifies dynamic risk factors = helps facilitates effective treatment = common language
- Worling, 2018

Issues With Popular Risk Prediction Tools

1. Research regarding risk prediction accuracy levels
2. 33%-100% of the risk factors are static: adolescents are not
3. Research regarding established risk prediction factors
4. Narrow age range (typically 12-18)
5. Dated language does not reflect changes in the field
6. Most tools not applicable for subgroups (e.g., females, noncontact offenses, bestiality, child abuse images…)
7. Arbitrary risk ratings with some tools (e.g., what does "High Risk" mean? "Moderate Risk?")
8. Only risk factors: ***no*** protective factors

Examples of Measures

1. PROFESOR – Protective + Risk Observations for Eliminating Sexual Offense Recidivism
2. YNPS – Youth Needs and Progress Scale
3. MEGA^{J} - Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing
4. MIDSA Multidimensional Inventory of Development, Sex, and Aggression
5. JSORRAT- Juvenile Sexual Offense Recidivism Risk Assessment Tool-II
6. J-SOAP – Juvenile Sexual Offender Assessment Protocol – II
7. J-RAT – The Juvenile Risk Assessment Tool

Risk and Need Assessment Measures ATSA Guidelines for Best Practice

- Improvement over unstructured clinical judgement
- Most empirically supported, independent evaluated, sex-offense-specific risk assessment
- Are not meant to stand alone
- Assessor knows the measure, understands literature around the measure, and understands limitations
- Know who and how to appropriately use the tool. If using it outside of guidelines, must list limitations.

Risk Levels per ATSA

8.17 Practitioners recognize that risk for reoffending is multi-determined and is influenced by individual, familial, situational, and other factors. Consequently, person-specific risk labels, such as "he or she is a high, low, or moderate risk" should be avoided and, if used, must be used cautiously and include the context. (ATSA Adolescent Guidelines, page 37)

- If label is used, must be in context of the environment such as High risk at mother's house!

ATSA Position on Registration

- It is the position of ATSA that Sex Offender Registration and Notification laws are not appropriate for children and adolescents adjudicated or convicted of sexually abusive behavior, and the application of such practices should be eliminated.
- Efforts should focus on evidence-based interventions that will prevent re-offense, facilitate healthier lives for these youth, and result in healthier and safer communities.

ATSA Recommendations on Registry

- End policies that subject children or adolescents to sex offender registration and notification requirements and related residence, education, and employment restrictions;
- Implement primary prevention interventions;
- Offer specialized treatment programs grounded within developmentally appropriate research, informed practices that incorporate trauma-informed practices and adhere to the principles of risk, need, and responsivity;
- Offer sexual education programs that address consent, healthy sexuality, and boundaries offered in an age-appropriate manner throughout childhood development;
- Offer treatment and other interventions that are sensitive to and address the adverse childhood conditions often experienced by at-risk youth (Adverse Childhood Experiences);
- A focus on protective factors that increase emotional, behavioral, and educational stability; and
- Engage family members and community support persons in an effort to maximize success in programs and promote stability and prosocial behaviors.

Pause for a Good Measure chat

- Want to talk more about assessments, come find me this afternoon!

Best Practice Assessment Review:

- Assessments are only as good as the information gathered during the interview and record reviews.
- ATSA Adolescent Practice Guidelines are based in the empirical framework of the Risk – Need – Responsivity Principles
- Calculated sexual recidivism rate at 2.75% (Caldwell, 2016)
- Assessments Inform – Not Predict
- Post –adjudication completion
- Utilizing a Risk and Need Assessment Measure

Treatment

Best Practices for Adolescents who have Engaged in Sexually Abusive Behaviors

Treatment for Adolescents

- Adolescents in general are diverse such as still developing, learning styles vary. For adolescents who have engaged in sexually abusive behaviors protective factors and risk associated with reoffending are also diverse.
- Therefore, Treatment for adolescents who have engaged in sexually abusive behaviors needs to consider all things adolescent and all things associated with risk of sexual reoffending among adolescents
- Treatment is driven by Assessment

Best Practices for Treatment include:

- A focus on dynamic risk factors
- Promoting safety while assisting with skill development
- Evidence Based Interventions that meet the Risks and Needs
- Include caregiver and/or parent
- Assess risk and protective factors in youth's environments
- Treatment in least restrictive environment
- Treatment is at the adolescent's developmental level
- Addresses both sexual behavior problems and conduct problems

What the Research is saying for Best Practices for Treatment

- Cognitive Behavioral Therapy (CBT)
- MI
- Skills-Based
- Multisystemic Approaches that involve caregivers
- BUT- is that all? Nope!

Treatment is MOST effective when includes principles of RNR

- Risk = intensity of treatment
- Need = focusing on factors related to recidivism; specific to the adolescent
- Responsivity = adapting and adjusting what treatment is used to meet the needs of the adolescent

But what really drives what we do?

Title IV-E Prevention Services Clearinghouse

Developed in accordance with the Family First Prevention Services Act (FFPSA)

https://preventionservices.abtsites.com/

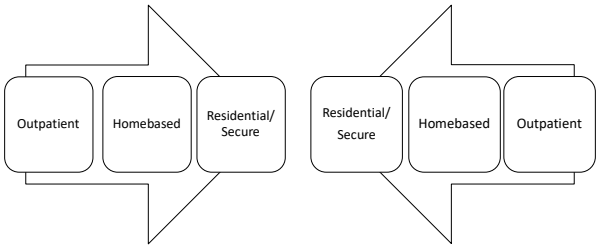
The California Evidence-Based Clearinghouse for Child Welfare

Indiana Family Preservation

- All services delivered under this Indiana standard must have as a foundation at least one evidence-based practice that is classified at a minimum as a "Promising Practice" on the California Evidence-Based Clearinghouse (CEBC)

https://www.cebc4cw.org/

Treatment on a Continuum



Providers for Treatment for Adolescents who have engaged in sexually abusive behaviors

- Knowledgeable on current research specific to this population
- Possess skills and knowledge on RNR
- Aware of own strength and weaknesses when treating this population
- Collaboration with other professionals in this population

Keys to Treatment Best Practice

- Treat the whole adolescent
- Engagement of adolescent and family/caregiver
- Motivate, how can you help the change process?
- Therapeutic Relationship with adolescent
- Assessment drives treatment
- Treatment is needs based that were identified in assessment
- Addressing sexual attitudes
- Includes healthy sexuality concepts
- Social and community supports
- Delinquency
- Social Skills components
- Parent/caregiver relationships

Treatment Concepts that are important

- Social skills
- Cognitive thinking errors
- The “how did this happen” (cycle, chain) connecting thoughts –feelings- behaviors
- Healthy relationships
- Increase in sexual knowledge

Moving to a lower level of care or Discharge from Treatment

- Established in foundations of RNR
- Does not mean DONE, means made progress. Progress on goals established to reduce the risk of sexual recidivism.
- Who is ever done with treatment?
- NOT based on
  - Completion of chapters
  - Completion of manuals
  - Completion of all goals

ATSA Adolescent Guidelines says it all….

10.38 Practitioners recognize and communicate that successful discharge from a treatment program/regimen indicates the adolescent and his/her caregivers, when appropriate, have demonstrated progress related to the goals and objectives of the individualized treatment plan designed to reduce the adolescent's risk to reoffend and increase stability and prosocial behaviors to such a degree that the adolescent's level of risk and needs supports a decrease in intensity of services or the ending of formal treatment. Successful completion does not indicate the individual's risk to reoffend has been eliminated completely.

Safety Planning

Why- Because it Works!

What did Caldwell say?

Why do we safety plan?

- Why is someone sitting in back?
- Why did you put your seatbelt on when driving?
- Why do we wear football pads and helmets?
- Coffee in am before talking to others?
- Others in normal day?

- Do we call them safety plans?
- Formal? Informal? Written and signed?
- Why do we have them- based on what?

Why it works = Brain Development

- Neuroplasticity – allows for the brain to change structurally and functionally related to experiences
  - Use it or lose it
  - Cow path example
- Brain maturity in mid 20's
  - Prefrontal cortex- one of last regions to mature, but significantly grows in adolescents
    - Equates to hope that new things can be learned

What do we safety plan for?

- What does the family/youth/community need?
- Safety planning is for concerning bx, acknowledged bx, ongoing disruptive bx, adjudicated/CHINS bx, and any other harmful bx
- Don't need courts to tell us to make plans
  - What do we do on a daily basis to keep ourselves safe?
    - Back to the beginning of the presentation- what is safety?

Safety plan is what?

- Current move in treatment to move away from no, can't, don't to do, assist, and keep safe
  - Easy to say no, but let's look at PROTECTIVE factors
    - Examples
  - Our brains like to be told yes, respond and relearn!
- Life Plans
- Good Lives Model

Big picture of Best Practice for Safety Planning

- Professionals are aware that best practice models indicate that, with successful treatment, most juveniles who commit sexual offenses do not commit further sexual offenses – and act accordingly every time.

How to plan?

ATSA Practice Guidelines

- Safety Plans must reflect and accommodate the lifestyles of those affected by them including developmental, co-morbidity, interpersonal skill, coping skill, access to resources, and likelihood of compliance variables – every time.
- The clinician advocates for the youth and his family and also Community Safety – knowing that both are clients every single time.
- Safety Planning/Treatment includes consideration and involvement of the family and available systems
- Safety Consideration is taken into any known or suspected trauma

How to plan continued

- ATSA Practice Guidelines continued
  - Safety Planning/Treatment identifies and builds on strengths of the child and family as tools for change
  - Safety planning matches the family's values on sex and sexuality
  - Interventions should require daily effort by the child and family members
  - Interventions are most effective when cognitive and behavioral coping strategies are emphasized toward promoting responsible behavior on the part of family members – skill building.

How to plan continued

- ATSA Practice Guidelines continued
  - Correcting cognitive distortions (thinking errors) and providing more adaptive attribution options enhances treatment outcomes.
  - The Professional is sensitive to his/her own personal and cultural biases in interactions and supervision of the youth and his/her family every time.
  - The Professional actively engages with a supervisor to monitor personal bias and to promote best practice standards for the client every time.

But really, how do we do this?

- Let's chat
  - What is your favorite way to do safety plans?
  - Templated forms or free forms?
  - Family or no family involvement in creating?
  - What do you call them?

What about technology ?

- How is it included in safety planning?
- My favorite, Live like it is 1989 with technology!
- How do you in your practice handle technology use among youth?

Remember -- to look for special exceptions!

- Know about exceptions – or extra rules
  - Is there court orders that have to be obtained – if and when?
  - No contact orders in place?
  - Clarification process – how does safety planning fit into it

How long is a safety plan good?

- Never expires?
- Best by date?
- Updates like software?

Best Practice Safety Planning

- Includes Components of the following:
  - Dynamic – fluid- adaptive
  - Reviewed -- updated -- always changing
  - Normal – healthy expectations
  - All parties must be in agreement that safety is a necessity
  - Community safety is a client

Clarification

What we know …… as clinicians

- Typically the abuser and victim will reunite on some level at some time
- Clarification and reunification processes increase the chances of success significantly over families reuniting independently when an abuser or victim leaves a service system.

Clarification versus reunification?

Clarification Process	Reunification Process
an ongoing process for family members to talk about the harm caused and the impact on everyone within the family system, - Face to face sessions or other available options - In a safe environment -With professionals to assist in the discussions and safety planning needs -Based on all ages of those involved	systematic and therapeutic process of bringing a family back together may include one or multiple individuals living outside of the nuclear family usually entails incremental visitation, starting with supervised and working towards extended in home visits, prior to a child returning to the primary residence

So this means what?

- Clarification does not equal reunification
- Reunification does not equal clarification
- ***It is a process- clarify, update safety plan, reunify, update safety plan, clarify, reunify more, update safety plan, reunify more, clarify more, and on and on and on……***

A non negotiable

- Clarification (on some level) must happen prior to reunification
- And why?

Five Things needed for Best Practice

1. Definition of who is on the team- family driven
2. Open goal oriented communication among all parties
3. Informed supervision
4. Safety planning for all at all times
5. Trained providers to work with youth with sexually harmful behaviors and children who have experienced sexually harmful behaviors

Clarification takes on many forms

Youth with harmful behaviors clarifies in many forms

- Parents from day of allegation – what did you do?
- Courts – admitting in court what happened
- On admit paperwork – questions asked of what happened that they are in treatment
- Parents asking more questions once treatment starts
- Providers asking for details as preparation for clarification
- Youth clarifying with self on beliefs and attitudes
- Siblings who are not direct victims

Victim clarification session looks like?

- What the victim needs!
- At the victim's age/developmental level
- Where the victim chooses. Safety first !
- All therapists are in agreement of the session process
  - Utilization of pre-established questions
  - Utilization of letters
- Structured –
  - Decreases anxiety
  - Roles are known
  - Safety is addressed

When does Victim clarification Happen?

- Face to face clarification session- may be first time youth see each other since abuse happened – high emotions are expected, here are a few ideas
  - Initial session may need to be a meet/greet supervised visit, then next session is clarifying the harm
  - Letters shared regarding life changes since last seen sibling
  - Pictures shared under supervision to see physical changes
- Activities that can help prepare for face to face clarification session
  - Sharing questions the victim has for the abuser to answer them back in writing or know what to expect
  - Abuser sharing a letter written to victim – addressing harm, planning for safety
  - Pictures – Art – Phone conversations
  - Other ideas?

Victim Clarification
Overall details Continued ….

- Who does what?
  - All parties are communicating to reach same goal – at least bi-weekly
  - Victim therapist- determines when victim is ready to initially begin clarification
    - Trauma symptoms are stabilized
    - Safety is addressed
  - Abuser therapist- determines when harmful youth is ready to initially begin clarification
    - Acknowledgement of harm
    - Understanding of requirements for safety
  - Family- support, answers questions, follows safety plans, completes own clarification if needed

Reunification at all levels

- Initially with parents or other support persons
- Safety adherence = increased reunification plans
- Clarification = adding victim into reunification plan
- Safety is ALWAYS addressed

Safety Planning within clarification and reunification

- For sessions, after sessions, and for visits
  - Safety maybe in back of mind as parties are excited of the family together
- Dynamic – fluid- adaptive
- Reviewed -- updated -- always changing
- Normal – healthy expectations
- All parties must be in agreement that safety is a necessity
- Community safety is a client
- Informed supervisors
  - Who can help the family?

Clinical adherence necessary – no matter how human we are

- As we stated at the beginning not all are able to do this, even those that do it, need support and guidance.
- Our personal worlds cannot collide with our professional worlds.
- Keeping a focus on the clinical needs of all involved will help guide and keep us on the proper track.

Combining it all together

- Best practices as each stage, some overlap
- Good quality therapy work goes a long way
- RNR is a base for all that we do
- No specific order on how to do things, it is individualized to each adolescent and family

Assessment

- Apsche, J., Ayland, L., Ballard, B., Barriball, K., Prescott, D. S., & Longo, R. E. (2010). Current Applications:Strategies for Working with Sexually Aggressive Youth and Youth with Sexual Behavior Problems (First ed.). Neari Press. Chapt 3 and 4
- Association for Treatment of Sexual Abusers. (2017). ATSA Adolescent Practice Guidelines for Assessment, Treatment and Intervention with Adolescents who Have Engaged in Sexually Abusive Behaviors 2017. ATSA Adolescent Practice Guidelines, 1–98. https://www.atsa.org
- Bonta, J & Andrews, The Psychology of Criminal Conduct, 6th Edition Routledge 2017
- Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. Psychology, Public Policy, and Law, 22(4), 414.
- Lewis, A. (2006). Understanding, Assessing and Rehabilitating Juvenile Sexual Offenders. Edited by Phil Rich. Wiley, Hoboken, New Jersey, 2003. ISBN 0–471-26635-3. Criminal Behaviour and Mental Health, 16(1), 67–68. https://doi.org/10.1002/cbm.15
- Murphy, W. D. (2017). The Safer Society Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended.

Treatment

- Deblinger, E., Mannarino, A., Cohen, J., Runyon, M., & Heflin, A. (2015). Child Sexual Abuse A Primer for Treating Children, Adolescents, and Their Nonoffending Parents (2nd ed.). Oxford University Press.
- Indiana Department of Child Services Sexually Harmful/Reactive Youth Standard, pages 226-248. https://www.in.gov/dcs/files/Effective_6_1_18_Community_Based_Service_Standard.pdf
- Indiana Department of Child Services, https://www.in.gov/dcs/files/Residential-Service-Standard-for-Youth-with-Sexually-Harmful-Behaviors-10.pdf
- Kahn, T. J. (2011b). Pathways: A Guided Workbook for Youth Beginning Treatment (4th ed.). Safer Society Press.
- Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. Guilford press.
- The California Evidence-Based Clearinghouse for Child Welfare. (2006). The California Evidence-Based Clearinghouse for Child Welfare Information and Resources for Child Welfare Professionals. https://www.cebc4cw.org/
- Title IV-E Prevention Services Clearinghouse. (2021). Title IV-E Prevention Services Clearinghouse. https://preventionservices.abtsites.com/
- Walsh, F. (2016). Strengthening Family Resilience, Third Edition (Third ed.). The Guilford Press.

Clarification

- Chaffin, M., (n.d.) *Reintegrating juvenile offenders into the family.* Available from the California Coalition on Sexual Offending: http://www.ccoso.org/library%20articles/04%20Chafin%20-%20adolescents.doc
- DeMaio, C. M., Davis, J. L., & Smith, D. W. (2006). The use of clarification sessions in the treatment of incest victims and their families: An exploratory study. *Sexual Abuse: A Journal of Research and Treatment, 18,* 27–39. doi:10.1177/107906320601800103
- Gil, E., & Roizner-Hayes, M. (1996). Assessing family readiness for reunification. In E. Gil (Ed.), *Systemic treatment of families who abuse* (pp. 175–197). San Francisco, CA: Jossey-Bass Publishers.
- Harper, B. M. (2012). Moving families to future health: Reunification experiences after sibling incest (Doctoral dissertation). Retrieved from the University of Pennsylvania: http://repository.upenn.edu/cgi/viewcontent.cgi?article=1027&context=edissertations_sp2
- Page. J. and Murphy, W. D. (2017). Community Reentry and Family Reunification. In S. Righthand and W. Murpy (Eds.) *The Safer Society: Handbook of Assessment and Treatment of Adolescents who have Sexually Offended.* (pp.291-323). Brandon, VT: Safer Society Press.
- Price, D. M. (2004). Rebuilding shattered families: Disclosure, clarification, and reunification of sexual abusers, victims, and their families. *Sexual Addiction & Compulsivity, 11*, 187–221. doi:10.1080/10720160490903701
- Thomas, J. (2004). Family intervention with young people with sexually abusive behavior. In G. O'Reilly, W. L. Marshall, & A. Carr (Eds.), *The handbook of clinical intervention with young people who sexually abuse* (pp. 315–342). Danvers, MA: Psychology Press.
- https://ccoso.org/sites/default/files/familyresolution.pdf

Safety Planning

- •ATSA. (2017). Practice Guidelines, Assessment, Intervention and Management with Adolescents Who Have Engaged in Sexually Abusive Behavior.
- •Barrett, Mary Jo., and Fish, Linda Stone. (2014). Treating Complex Trauma: A Relational Blueprint for Collaboration and Change
- •Bateman, Jackie and Milner, Judith.(2015). Children and Young People: whose behavior is sexually concerning or harmful: Assessing risk and Developing Safety plans. Jessica Kingsley Publishers.
- •Caldwell, M. F. (2016). Quantifying the decline in juvenile sexual recidivism rates. Psychology, Public Policy, and Law, http://dx.doi.org/10.1037/law0000094, 1-13.
- •Powell, K. M. (2015) A Strengths-Based Approach for Intervention with At-Risk Youth. Research Press.
- •Tabachnick, J., & Pollard, P. (2016) Considering family reconnections and reunification after child sexual abuse: A road map for advocates and service providers. Enola, PA: National Sexual Violence Resource Center.

The End

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