


800 Series: Juvenile Sexual Offender Treatment Program			
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 JUSTICE CABINET DEPARTMENT OF JUVENILE JUSTICE POLICY AND PROCEDURES	REFERENCES: 505 KAR 1:160
CHAPTER: JUVENILE SEXUAL OFFENDER TREATMENT PROGRAM	AUTHORITY: KRS 15A.0652 KRS 635.500
SUBJECT: Definitions	
POLICY NUMBER: 800	
TOTAL PAGES: 1	
EFFECTIVE DATE: 11/01/2019	
APPROVAL: Raymond F. DeBolt, COMMISSIONER	

I. POLICY


The following definitions shall apply to the Department of Juvenile Justice (DJJ) Policy and Procedures Manual Policies 801-806 and Standard Operating Procedures Manual for the Treatment of Declared Juvenile Sexual Offenders.

II. APPLICABILITY

This policy shall apply to all DJJ staff, and approved private individuals or agencies providing services to declared juvenile sexual offenders.

III. DEFINITIONS

- A. “Approved Treatment Professional” means a person not employed by DJJ who is approved by the Executive Committee as outlined in Policy 806 to provide treatment services to declared juvenile sex offenders in either a residential or community setting.
- B. “Assessor” means a person not employed by DJJ who is approved by the Executive Committee as outlined in Policy 806 to conduct juvenile sex offender risk assessments on youth as ordered by the juvenile session of the District Court.
- C. “Juvenile Sexual Offender” or “JSO” is defined by KRS 635.505.

	JUSTICE AND PUBLIC SAFETY CABINET DEPARTMENT OF JUVENILE JUSTICE POLICY AND PROCEDURES	REFERENCES: 505 KAR 1:160; 4-JCF-5C-01; 3-JCRF-5C-01
	CHAPTER: JUVENILE SEXUAL OFFENDER TREATMENT PROGRAM	AUTHORITY: KRS 15A.065 KRS 635.500
	SUBJECT: Treatment Program for Declared Juvenile Sexual Offenders	
	POLICY NUMBER: 801	
	TOTAL PAGES: 2	
EFFECTIVE DATE: 11/01/2019		
APPROVAL: Raymond F. DeBolt		, COMMISSIONER

I. POLICY

The treatment program for declared juvenile sex offenders (JSOs) shall be based on guiding principles that are consistent with an evidenced based framework that supports effective care. Department of Juvenile Justice Policy and Procedures (DJJPP) Chapter 8 and the Standard Operating Procedures (SOP) Manual for the Treatment of Declared Juvenile Sexual Offenders shall only apply to declared JSOs and shall not apply to juveniles who have been adjudicated guilty of a sexual offense, but have not been declared a JSO.

II. APPLICABILITY

This policy shall apply to all Department of Juvenile Justice (DJJ) programs, DJJ staff, and approved private providers or agencies providing services to declared JSOs.

III. DEFINITIONS

Refer to Policy 800.


IV. PROCEDURES

- A. DJJ shall develop and implement a juvenile sex offender treatment program for declared juvenile sex offenders. Reference KRS 635.500 635.510. The treatment program shall be established in the SOP Manual for the Treatment of Declared Juvenile Sexual Offenders.
- B. DJJ shall develop and implement a standardized process for the treatment of declared juvenile sexual offenders.

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V. MONITORING MECHANISM

Monitoring of this policy and corresponding standard operating procedures shall be conducted by the Division Director of Community and Mental Health Services and the Quality Assurance Branch on an annual basis.

	JUSTICE AND PUBLIC SAFETY CABINET DEPARTMENT OF JUVENILE JUSTICE POLICY AND PROCEDURES	REFERENCES: 505 KAR 1:160
CHAPTER: JUVENILE SEXUAL OFFENDER TREATMENT PROGRAM		AUTHORITY: KRS 15A.065
SUBJECT: Polygraph Examinations		
POLICY NUMBER: 803		
TOTAL PAGES: 5		
EFFECTIVE DATE: 11/01/2019		
APPROVAL: Raymond F. DeBolt		, COMMISSIONER

I. POLICY

Polygraph examinations may be used in exceptional cases for the purpose of detecting deception or verifying the truth of statements of a youth in limited situations where the youth's veracity has become a critical treatment issue. For example, the youth denies the committing offense and is unable to progress in treatment because of that denial. However, polygraphs shall never be used to determine the prior victimization of an offender, nor shall any youth be referred for a polygraph when the youth denies the committing offense if the youth has an appeal pending.

II. APPLICABILITY

This policy shall apply to all Department of Juvenile Justice (DJJ) programs, DJJ staff, and approved private individuals or agencies providing services to declared JSOs.

III. DEFINITIONS

Refer to Policy 800.

IV. PROCEDURES

A. Persons meeting the following requirements may be approved by the agency to provide the polygraph examinations. Required qualifications are:

1. The polygraph examiner shall be a specifically trained clinical polygraph examiner and a graduate from an American Polygraph Association (APA) accredited school.
2. The polygraph examiner shall be a member of APA and have completed the APA approved Post Conviction Sex Offender Treatment training (PCSOT).

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- B. A description of the qualifications and training received by each polygraph examiner, to include diplomas or certifications received and current association membership, shall be kept on file in the office of the Director of Community and Mental Health Services. A copy shall be maintained by the Chief of Mental Health Services.
- C. Polygraph examinations shall only be conducted under limited circumstances as outlined in Section I above.
- D. Procedures for Examination
 - 1. Referral for Polygraph Examination: The treatment team may refer those youth who meet the following criteria:
 - a. Chronological age of fourteen (14) or older, and a minimum functioning of age equivalency of twelve (12) years. Standardized psychometric testing shall be employed when there is doubt about a youth's level of functioning;
 - b. Capacity for abstract thinking;
 - c. Capacity for insight;
 - d. Capacity to understand right from wrong;
 - e. Ability to tell truth from lies;
 - f. Ability to anticipate rewards and consequences for behavior; and
 - g. Consistent orientation to date, time, and place.
 - 2. The polygraph examiner shall make the final recommendation of suitability for polygraph examination and shall not conduct the polygraph examination with youth when indicators exist that results would be invalid.
 - 3. The treatment team shall determine and document in case files the rationale for polygraph testing.
 - 4. The treatment team shall not refer youth when any of the following are present:
 - a. Diagnosis of psychotic thought disorder;
 - b. Lack of contact with reality;
 - c. Presence of acute pain or illness;
 - d. Presence of acute distress;
 - e. Medication changes within the past thirty (30) days;
 - f. Mean age equivalency (MAE) or Standard Age Score (SAS) is below twelve (12) years (per standardized psychometric testing); or
 - g. Any other indicator exists that results would be invalid.

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5. A youth shall not be referred without full, informed consent of the parent or legal guardian and the informed assent of the youth.
6. All referrals shall be reviewed and subject to approval by the Chief of Mental Health Services.

E. Scheduling for Polygraph Examination

1. The treatment provider shall contact the polygraph examiner to schedule the time and location for the examination.
2. The Department of Public Advocacy (DPA) shall be notified fifteen (15) days prior to the scheduling of the polygraph examination.
3. The treatment provider shall maintain a log of all polygraph examinations including the youth's name, Juvenile Service Worker (JSW), polygraph examiner conducting the examination, date and place of the examination, and results.

F. Pre-examination Procedures with Youth

1. The treatment provider shall explain the polygraph process and have the client complete the appropriate documents.
2. The polygraph examiner shall review the polygraph examination procedures with the youth.

G. Attendance at Examination

1. The treatment provider may attend polygraph examinations, but shall not be present in the examination room, unless directed to be in the room by the polygraph examiner. If the treatment provider is not present for the examination, the treatment provider shall be available for the polygraph examiner to contact during the examination if necessary.
2. A third party, including an attorney for the youth, shall not be in the examination room at the time of the polygraph examination.
 - a. The youth may consult with the attorney before the examination.
 - b. The youth may consult with the attorney upon completing the examination and before post-test interview by the polygraph examiner, which may include the treatment provider.
 - c. After the youth enters the examination room, the polygraph examiner shall provide an outline of questions that will be asked during the polygraph examination to an attorney for the youth, if an attorney for the youth attends. The attorney for the youth shall not consult with the youth about the outline of questions, but the attorney for the youth may object to a question. If an attorney for the youth objects to a question, the polygraph examiner may agree that the question will not be asked. If the

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polygraph examiner and an attorney for the youth do not agree about whether a question should be asked, then DJJ Legal shall be consulted to resolve the issue.

3. Even if the treatment team clears the youth for the examination, the polygraph examiner shall independently determine if the youth is suitable for an examination considering the youth's age, physical, mental, or emotional state.

H. Post-test Interview

1. Upon completion of the polygraph examination, the polygraph examiner may conduct a post-test interview of the youth.
2. The youth shall be informed of the results and may decline to participate in the post-test interview.
3. The treatment provider and the polygraph examiner may consult after the polygraph examiner's post-test interview.
4. The treatment provider may debrief the youth upon completion of the polygraph examination.

I. Disclosure of Victimization

1. A DJJ counselor shall be available during the polygraph examination in the event that a youth discloses sexual victimization during the course of the interview.
2. If the youth discloses sexual victimization, this shall be reported to DCBS per KRS 620.030 and the youth shall be provided all appropriate services to properly address the victimization.

J. Results of Polygraph Examination Process

1. Team Consultation
 - a. The polygraph examiner shall disclose all information that is discussed in the examination to the treatment provider and the JSW.
 - b. Results of the examination shall be logged into the youth's case file and the polygraph examination log.
 - c. If no deceptions are indicated in the polygraph examination, the treatment provider shall record the results in the running record and polygraph examination log and notify the respective supervisors.
 - d. If the examination indicated deceptive results on any question, the treatment provider shall consult with the respective supervisors and the JSW to determine the appropriate treatment strategies to be employed in response to the results of the examination.

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2. The treatment provider shall record that a polygraph was completed and include any treatment recommendations in the running records.

V. MONITORING MECHANISM

Monitoring of this policy and corresponding standard operating procedures shall be conducted by the Chief of Mental Health Services, the Division Director of Community and Mental Health Services, and the Quality Assurance Branch on an annual basis.



**JUSTICE CABINET
DEPARTMENT OF
JUVENILE JUSTICE
POLICY AND PROCEDURES**

**REFERENCES:
505 KAR 1:160**

**CHAPTER: JUVENILE SEXUAL
OFFENDER TREATMENT PROGRAM**

**AUTHORITY: KRS 15A.065;
KRS 635.510**

**SUBJECT: Private Provider Application,
Approval, and Renewal Process for Juvenile
Sexual Offender Treatment or Assessor
Status**

POLICY NUMBER: 806

TOTAL PAGES: 6

EFFECTIVE DATE: 11/01/2019

APPROVAL: Raymond F. DeBolt

, COMMISSIONER

I. POLICY

The Department of Juvenile Justice (DJJ) has been authorized to approve training and supervision criteria for individuals who provide sexual offender treatment for declared juvenile sexual offenders (JSOs) committed to DJJ or who conduct juvenile sexual offender risk assessments of youth (KRS 635.510, KRS 635.515 and KRS 635.520). This authority shall include the standards for treatment provided by private agencies, state operated community offices, private residential programs, and state operated residential settings.

II. APPLICABILITY

This policy shall apply to any private provider or agency providing treatment or assessment services to a declared JSO committed to the Department. This policy shall apply to DJJ staff electing to go through this approval process.

III. DEFINITIONS

Refer to Policy 800.

IV. PROCEDURES

A. DJJ shall approve the qualifications, training, and supervision requirements for private providers seeking to provide juvenile sexual offender treatment or conduct juvenile sexual offender risk assessments for declared juvenile sexual

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- offenders committed to the Department. Department staff may apply for approval.
- B. An Executive Committee (Committee) shall oversee the review of applications, make decisions regarding approved treatment professional and assessor status, and shall include the following members or their designees:
1. Chief of Mental Health Services;
 2. DJJ Regional Psychologist representative;
 3. Division Director of Community and Mental Health Services;
 4. Regional Division Director;
 5. Division Director of Program Services;
 6. Division Director of Professional Development; and
 7. Representative of a private agency providing juvenile sexual offender treatment.
- C. The Committee shall provide notice of the initial application process in writing. A private provider shall be required to submit the application and appropriate documentation for review by the Committee. These materials shall include:
1. Initial application;
 2. Documentation of training requirements, along with a certificate of hours completed;
 3. Documentation of supervised clinical experience;
 4. Signed criminal record forms; and
 5. Copy or proof of professional license, if applicable.
- D. A private provider shall be made aware of the date of the Committee review meeting and shall submit the application and documentation to the Committee or designee two (2) weeks prior to December 31 of each year. If application and documentation is received less than two (2) weeks prior to December 31, the application shall not be reviewed until the next scheduled meeting.
- E. The Chief of Mental Health Services or designee shall maintain all records for any private provider applying for approval status or who has been granted approval status by the Department.
- F. A private provider that is not an approved treatment professional, who is providing treatment services to a declared juvenile sexual offender committed to DJJ and placed in the community, may continue to provide services contingent upon completing the application process and receiving approval status within forty-five (45) days. DJJ shall assume no fiscal responsibility for treatment provided by a private provider.

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- G. Exceptions to the application and approval process may be made on an emergency basis with the approval of the Chief of Mental Health Services.
- H. Requirements for Approved Treatment Professional Status to Provide Juvenile Sexual Offender Treatment
 - 1. To provide juvenile sexual offender treatment in a community outpatient setting the following qualifications shall be required:
 - a. Master's Degree in social work, psychology, counseling, or a related field;
 - b. Completion of the Juvenile Sexual Offender Treatment Provider Certification (JSOTPC) provided by DJJ or its equivalent;
 - c. Completion of 160 direct contact hours involving the treatment of juvenile sexual offenders and their families;
 - d. Receipt of two (2) hours per month of clinical supervision by a licensed mental health professional, which shall occur concurrently with the 160 direct contact hours; and
 - e. Completion of a DJJ approved group counseling training course or graduate course, except if the applicant is licensed or is authorized by a Kentucky mental health regulatory board to practice without clinical supervision.
 - 2. To provide juvenile sexual offender treatment in a residential setting the following qualifications shall be required:
 - a. Bachelor's Degree in social work, psychology, counseling, or a related field;
 - b. Completion of the Juvenile Sexual Offender Treatment Provider Certification (JSOTPC) provided by DJJ or its equivalent;
 - c. Completion of 160 direct contact hours involving the treatment of juvenile sexual offenders and their families;
 - d. Receipt of two (2) hours per month of clinical supervision by a licensed mental health professional, which shall occur concurrently with the 160 direct contact hours; and
 - e. Completion of a DJJ approved group counseling training course or graduate course, except if the applicant is licensed or is authorized by a Kentucky mental health regulatory board to practice without clinical supervision.
- I. Requirements for Approved Assessor Status to Conduct Juvenile Sexual Offender Risk Assessments
 - 1. To conduct a juvenile sexual offender risk assessment the following qualifications shall be required:

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- a. Master's Degree in social work, psychology, counseling, or a related field;
 - b. Completion of the JSOTPC provided by DJJ or its equivalent;
 - c. Completion of the DJJ sponsored juvenile sexual offender assessment training or equivalent;
 - d. Completion of ninety (90) hours of juvenile sexual offender risk assessment experience; and
 - e. Receipt of two (2) hours per month of supervision by a licensed mental health professional, which shall occur concurrently with the ninety (90) hours of assessment experience.
2. The private provider shall complete four (4) juvenile sexual offender risk assessment reports and submit those reports to the Committee for review.
 - a. The reports may be all initial assessments or one (1) reassessment and three (3) initial assessments.
 - b. The private provider may use any juvenile sexual offender risk assessment instruments being utilized in their current job, but shall also include the risk assessment instruments utilized by the Department.
 - c. If the private provider includes instruments other than the instruments utilized by the Department, the private provider shall submit a copy of that instrument along with the reports.
 - d. All four (4) reports may be submitted at the same time or may be submitted one (1) at a time.
- J. A request to have an equivalent course or training approved by the Department, to meet minimum requirements for initial approved treatment professional or assessor status, shall be submitted in writing to the Committee. The request shall include:
 1. An outline of the course or training;
 2. Description of the content;
 3. Dates attended;
 4. Qualifications of the provider of the course or training; and
 5. Certificate of completion.
- K. Renewal of Approved Treatment Professional or Assessor Status
 1. The Committee shall provide notice of the renewal application process in writing. An approved treatment professional or assessor shall be required to submit the application and appropriate documentation for review by the Committee. These materials shall include:

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- a. Renewal application;
 - b. Documentation of training requirements, along with a certificate of hours completed;
 - c. Signed criminal record forms; and
 - d. Updated copy or proof of professional license, if applicable.
2. An approved treatment professional or assessor shall submit the renewal application and documentation to the Committee or designee two (2) weeks prior to December 31 of each year. If the application and documentation is received less than two (2) weeks prior to December 31, the application shall not be reviewed until the next scheduled meeting.
3. The approved treatment professional or assessor shall complete six (6) hours each calendar year of training related to juvenile sexual offender issues.
4. Any training sponsored or provided by the Department shall be approved for the required six (6) hours of training for renewal. Requests for approval of other trainings shall be submitted in writing to the Committee. The request shall include:
 - a. A description of the training and course content;
 - b. The notice or brochure of the training;
 - c. Qualifications of the provider of the course or training; and
 - d. The length of the training.
- L. The Department shall reserve the right to deny or rescind approval of any private provider or approved professional or assessor if the individual:
 1. Does not meet minimum training and supervision standards;
 2. Has been convicted of or pled guilty to a felony criminal offense or misdemeanor offense against a person;
 3. Had a domestic violence protective order issued against him or her within the previous five (5) years;
 4. Failed to be in compliance with ethical standards of professional practice as promulgated by the Kentucky licensing or certifying body under which the individual has professional status;
 5. Has a substance abuse disorder as defined in KRS 222.005(12);
 6. Falsified any information or documentation or concealed a material fact, in the application or documentation submitted for approval;
 7. Failed to comply with directives of the Committee;
 8. Failed to comply with procedures outlined in DJJ Policy;

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9. Accepted a gift or favor from a juvenile sexual offender being assessed or in treatment, from the family of the juvenile sexual offender being assessed or in treatment, or from their agent; or
10. Provided a gift or favor to a juvenile sexual offender being assessed or in treatment, to the family of a juvenile sexual offender being assessed or in treatment, or to their agent.

V. MONITORING MECHANISM

Monitoring of this policy and corresponding standard operating procedures shall be conducted by the Chief of Mental Health Services, the Division Director of Community and Mental Health Services, and the Quality Assurance Branch on an annual basis.

Standard Operating Procedures Manual for the Treatment of Declared Juvenile Sexual Offenders

11/01/2019

Kentucky Department of Juvenile Justice

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Applicability Statement

This Standard Operating Procedures (SOP) Manual shall only apply to those youth who are declared Juvenile Sexual Offenders (JSOs) per KRS 635.510 except as provided in Section II regarding post adjudication assessments.

Section I - Confidentiality

- A. Communications with JSOs shall be confidential as set forth in KRS 635.527 (Communications made in the application for or in the course of a child sexual offender's diagnosis and treatment in the program, between a sexual offender or member of the sexual offender's family and any employee of the department who is assigned to work in the program, or any approved provider as defined in KRS 17.500, shall be privileged from disclosure in any civil or criminal proceeding, other than proceedings to determine the sentence, unless the sexual offender consents in writing to the disclosure or the communication is related to an ongoing criminal investigation. The privilege created by this section shall not extend to disclosures made for the purpose of determining whether the sexual offender should continue to participate in the program. The provisions of KRS 620.030 shall not apply to a communication made, received, or overheard if the communication is made pursuant to this section.).
- B. The Juvenile Service Worker (JSW) or treatment provider shall notify the youth in writing of their rights regarding confidentiality pursuant to KRS 635.527 (The child sexual offender shall be informed in writing of the limits of the privilege created by this section.). The Department of Juvenile Justice (DJJ) shall afford the youth the opportunity to speak with their attorney prior to signing any waiver of confidentiality as provided by KRS 635.527. A waiver shall not be accepted unless the waiver is signed by both the youth and their attorney.

Section II – Sex Offender Specific Assessment

- A. All youth eligible to be declared a JSO under KRS 635.505(2)(a)–(g) shall be referred for a juvenile sexual offender assessment by the JSW to the Regional Psychologist.
- B. At the time of adjudication on an offense under KRS 635.505(2), the JSW shall request a separate disposition. The JSW shall request that the separate disposition date be set at least six (6) weeks after the date of the adjudication. The JSW shall additionally request a court order for the completion of a juvenile sexual offender assessment. The JSW shall make the referral for assessment to the Regional Psychologist within three (3) business days following adjudication.
- C. The JSW shall, at the time of referral, provide or request through means of release of information, the following information, as available, to the mental health assessor:
 - 1. Police interview transcripts or auditory and video recordings;
 - 2. Victim impact statement;
 - 3. Legal history including other charges and dispositions;
 - 4. Current petition and all other related court calendars and docket sheets, and any audio or video of an adjudication hearing or trial;
 - 5. Educational information including attendance, special education identification, and copy of last psychological or psycho-educational evaluation, as applicable;
 - 6. Previous outpatient counseling and evaluations, as applicable;
 - 7. Previous psychiatric hospitalizations and evaluations, as applicable; and
 - 8. Child protective services history, as applicable.
- D. The sex offender specific assessment shall be completed by the Mental Health Branch with the participation of the youth and the parent or caregiver.
- E. The sex offender specific assessment shall identify the source of all outside information. The assessment shall take into account all available information and not rely solely on one (1) source. The assessment shall contain all the components outlined in KRS 635.505(3) with required content to include:
 - 1. Identifying information:
 - a. Name;
 - b. Age; and
 - c. Date of Birth;
 - 2. Dates of evaluation;
 - 3. Date of report;
 - 4. Assessor's name and credentials;
 - 5. Reason for referral;
 - 6. Data sources from Section II. C., which were relied upon;
 - 7. Social Development and History;
 - 8. Substance Use History;
 - 9. Medical History, including any medical diagnosis of a disability;

10. Educational History, including an estimate of intellectual functioning, if available. If the Educational History indicates that the youth has an Intelligence Quotient (IQ) of seventy (70) or below this shall be noted in the assessment (KRS 635.505 and 635.510);
 11. Legal History:
 - a. Current and past offenses; and
 - b. Number of victims, ages, and relationships to offender;
 12. Family History, including ecological factors;
 13. Sexual History, including the following information, if applicable:
 - a. Sexual knowledge;
 - b. Sexual abuse victimization;
 - c. History of sexually abusive behavior or sexually inappropriate behaviors;
 - d. Dating and sexual relationships abuse issues;
 - e. History of masturbation;
 - f. History of deviant sexual interest, fantasy, arousal, or pornography; and
 - g. History of sexual interest, fantasy, arousal, or sexual activity with animals;
 14. The current functioning and behavior of the youth for the past six (6) months including the observations of the parent or caregiver and the self-report of the youth;
 15. Other mental health assessments or treatment information, which may have been provided to the assessor;
 16. Strengths, motivation, and prosocial living;
 17. Protective factors;
 18. Information regarding the risk for reoffending utilizing available risk assessment tools as well as clinical judgment by the mental health assessor, including a specific statement for each assessment tool used related to validity, reliability, and limitations of the instrument;
 19. Summary section, which shall summarize all information included in the report (Section II. E. 1-18), including information regarding the youth's risk of reoffending; and
 20. Recommendations section, which shall:
 - a. Focus on:
 - i. The individual treatment needs of the youth to address the identified sexual behavior problems, if any;
 - ii. A recommendation of whether or not the youth should be declared a juvenile sex offender;
 - iii. A recommendation for the most appropriate treatment modality; and
 - iv. The least restrictive environment in which that treatment can be provided to the youth; and
 - b. Not address the risk of reoffending.
- F. The youth and parent or caregiver shall be given written information regarding the Health Information Portability and Accountability Act of 1996 (HIPAA), by the

JSW and the Mental Health Branch assessor which shall be acknowledged in writing by the youth and parent or caregiver. If the youth, parent or caregiver refuses to sign the acknowledgment this shall be documented in the youth's individual client record (ICR). The HIPAA and acknowledgement shall be mailed to the parent or caregiver in situations when the parent or caregiver is not available, with a request that the acknowledgement be signed and returned.

- G. The youth shall not be required to describe or discuss his committing offense and the assessor shall not use the youth's refusal as an indicator of risk.
- H. The completed sex offender specific assessment shall be forwarded by the mental health assessor to the Regional Psychologist for review and approval within seven (7) business days prior to the disposition date. If the Regional Psychologist completes the assessment it shall be reviewed and approved by the next line supervisor.
- I. The sex offender specific assessment shall be completed, reviewed, and approved by the Regional Psychologist five (5) business days prior to the disposition date. The sex offender specific assessment shall be provided to the JSW four (4) business days prior to the disposition date. The JSW shall submit this report along with the Predisposition Investigation (PDI) to the youth's attorney, the prosecutor, and the court three (3) business days prior to disposition per KRS 610.100.
- J. For youth who are in Circuit Court and a Presentence Investigation (PSI) report is ordered, the sex offender specific assessment shall be completed, reviewed, and approved by the Regional Psychologist ten (10) business days prior to the sentencing date. The sex offender specific assessment shall be provided to the JSW seven (7) business days prior to the sentencing date. The JSW shall submit this report along with the PSI to the youth's attorney, the prosecutor, and the court five (5) business days prior to sentencing.
- K. If requested by the parent or caregiver, a meeting shall be held by the mental health assessor to discuss a summary of the results and the recommendations, based on the evaluation. A copy of the summary and the recommendations may be provided to the youth and parent or caregiver if requested. Reference DJJPP Chapter 1 (Records Request).
- L. If at disposition the court does not declare the youth a JSO no further action shall be taken in this manual.

Section III - Juvenile Sexual Offender Specific Treatment Components

- A. The Sexual Offender Treatment Program (SOTP) is a continuum of treatment, which may include services provided in the community, in a residential setting, or in a combination thereof.
- B. Unless otherwise ordered by the court, sex offender treatment shall be continuously provided while a case is on appeal with the exception of describing or admitting to the committing offense. If a youth's case is on appeal, the youth may complete their treatment plan and be discharged from residential placement.
- C. The Juvenile Sexual Offender Treatment Components shall:
 - 1. Incorporate social learning, cognitive-behavioral, and behavioral skills-based approaches;
 - 2. Be the holistic treatment of the youth, taking into consideration the diverse and socio-ecological, dynamic nature of adolescent development;
 - 3. Be assessment-driven, including determination of criminogenic needs, protective factors and normative or atypical sexual behaviors with identification of contributing factors and intervention needs;
 - 4. Encompass efforts by the treatment provider to include caregivers and other positive supports to foster youth and family engagement and to enhance treatment motivation;
 - 5. Incorporate guiding principles of healthy social, psychological and cognitive development to enhance prosocial, healthy relationships and healthy lives;
 - 6. Focus on research supported dynamic factors related to sexual recidivism;
 - 7. Focus on research supported dynamic factors related to nonsexual recidivism criminogenic needs, if indicated;
 - 8. Facilitate the development of positive therapeutic relationships to enhance treatment response and personal responsibility; and
 - 9. Focus on treatment targets commonly associated with sexual recidivism, as deemed relevant for an individual youth or his or her family.
- D. Relevant treatment targets specific to sexual recidivism to be evaluated for inclusion on a youth's treatment plan shall include:
 - 1. Social Isolation, Low Social Competence;
 - 2. Attitudes Supportive of Abusive Behavior;
 - 3. Parent-Adolescent Relationships, including healthy family living plan and enhancing relationships and caregiver capacity to supervise, monitor, and intervene;
 - 4. General Self-Regulation deficits;
 - 5. Healthy Sexuality including sex education, atypical sexual interests, sexual drive and preoccupation, if present, and sexual self-regulation;
 - 6. Social-ecological factors, including family, social and community supports;
 - 7. Nonsexual delinquency, including antisocial orientation, beliefs, attitudes and peer associations, if relevant; and
 - 8. Accountability and responsibility for sexual offending, including but not limited to healthy self-regulation planning and victim recognition and awareness.
 - 9. For youth not admitting to the sexual offending behavior the treatment provider shall consult with the treatment team, including the regional psychologist if applicable, for possible adjustments to the treatment plan to allow for progression in treatment.
- E. Additional areas of consideration for adjunct treatment targets may include:

1. Community Law Education;
 2. School Behavior Issues;
 3. Personal Victimization and Other Trauma History;
 4. General Mental Health Issues;
 5. Substance Abuse Treatment; or
 6. Situational, Environmental, Family, or System Issues.
- F. A youth declared a JSO shall be committed to the custody of DJJ pursuant to KRS 635.515 and shall receive sexual offender treatment for up to three (3) years. The time period of sexual offender treatment may be extended for one (1) additional year by the sentencing court upon motion of DJJ. The JSO shall not remain in the care of DJJ after the age of twenty-one (21) years.
- G. Declared Juvenile Sexual Offender Tracking
1. DJJ shall maintain a Juvenile Sexual Offender Tracking System (JSOTS).
 2. For a youth to be entered on JSOTS, the JSW shall complete a Part I Initial Tracking form and submit the form to the JSOTS Administrator, located in the DJJ Central Office, within thirty (30) days of disposition.
 3. The JSOTS Administrator shall:
 - a. Enter the data from the Part I form into the tracking database;
 - b. Generate the Part II tracking form; and
 - c. Send the Part II tracking form to the JSW.
 4. The JSW shall complete the Part II form and return it to the JSOTS Administrator within ten (10) business days.
 5. Per KRS 635.515(5), DJJ is required to send the committing judge a written report every sixty (60) days from the date of disposition. The JSW shall complete the sixty (60) day report to the court as described in Sections III G and H.
 6. The JSW shall provide the JSOTS Administrator with a copy of each sixty (60) day report that is sent to the court.
 7. The JSOTS Administrator shall send a monthly report showing DJJ's compliance with KRS 635.515 to each Community Regional Manager, Juvenile Services District Supervisor (JSDS), Facilities Regional Administrator (FRA), and Superintendent on the tenth (10th) of each month.
 8. A youth shall be removed from JSOTS under one (1) of the following conditions for which the JSW shall provide supporting documentation to the JSOTS Administrator:
 - a. The youth has received the maximum years of treatment per KRS 635.515(1);
 - b. The youth was sentenced as a Youthful Offender (YO) and has been transferred to the Department of Corrections (DOC);
 - c. The youth has reached age twenty-one (21);
 - d. The youth has completed the treatment program prior to the statutory maximum and was released from commitment upon recommendation by DJJ; or

- e. The youth's commitment has been terminated or suspended by the court.
- H. Treatment of Declared Juvenile Sexual Offenders with Community Placement
1. If a youth is in a community placement, the JSW assigned the case management responsibilities shall request treatment from the Regional Psychologist or designee within two (2) business days of disposition or upon return from an out-of-home placement. This request is not required when the youth is seeing a private provider prior to disposition and the parent or caregiver wants the youth to continue seeing the private provider. The provider shall be approved by DJJ. Reference DJJPP Chapter 8 (Private Provider Application, Approval, and Renewal Process for Juvenile Sexual Offender Treatment or Assessor Status).
 2. For youth whose treatment is provided by a DJJ approved professional, the JSW shall provide the private professional with the DJJ juvenile sexual offender treatment components, ensure the private professional agrees to address the mandatory components within the youth's treatment, and inform the private professional of their responsibility to provide a treatment agreement to the youth per KRS 635.515 (3). Reference DJJPP Chapter 8 (Private Provider Application, Approval, and Renewal Process for Juvenile Sexual Offender Treatment or Assessor Status).
 3. The Regional Psychologist, or designee, shall assign the treatment provider within two (2) business days of receipt of the request. The Mental Health Branch staff shall contact the youth and parent or caregiver to schedule an initial appointment within five (5) business days of receipt of referral from the Regional Psychologist.
 4. The parent or caregiver shall be provided orientation to treatment by the Mental Health Branch staff at the first meeting. The Mental Health Branch staff shall explain treatment expectations for the youth and parent or caregiver.
 5. The provider of the sexual offender specific treatment shall develop an individual treatment plan (ITP) with the youth, parent or caregiver, and JSW to outline the expectations and provision of the sexual offender treatment. Reference DJJPP Chapter 3 (Individual Treatment Planning and Aftercare Planning).
 6. The Mental Health Branch staff shall complete a treatment agreement on all youth who are on conditions of supervised placement that details the responsibilities of the declared juvenile sexual offender, the parent or caregiver, and the program. These responsibilities shall include attendance, participation in education, participation in planning and completion of treatment goals, curfew, home visits, participation in parenting groups and family counseling, continued contact with the program, schools, and court, insurance of legal rights, and discharge criteria as required in KRS 635.515(3).
 7. The Mental Health Branch staff shall review the acknowledgement of HIPAA privacy practices and obtain all necessary signatures.
 8. The Mental Health Branch staff shall inform the youth and parent or caregiver in writing of the confidentiality rights as established in KRS 635.527 and shall inform the youth and parent or caregiver of the role of the treatment team.

9. Releases of information shall be obtained, as needed, from the youth and parent or caregiver to share appropriate information with collateral agencies, to include school systems and other individuals or agencies providing services.
 10. Treatment shall be provided to address the needs and risks of the juvenile. Reference DJJPP Chapter 6 (Case Planning and Participation in Treatment Planning) and (Community Mental Health Operations).
 11. The mental health clinician shall address the sexual offending behavior in the ITP. All treatment plans shall be completed in accordance with DJJ Policy.
 12. The youth and parent or caregiver shall be required to cooperate with the sexual offender treatment provider pursuant to KRS 610.160.
 13. Reviews of the youth's progress shall be conducted every sixty (60) days regardless of the youth's placement as required by KRS 635.515 and a court report generated. This sixty (60) day court report shall include information about treatment received by the juvenile sex offender and parent or caregiver, assessment of the offender's current condition, and recommendations of the staff. The JSW shall prepare the report for the court incorporating the evaluation of how the youth and parent or caregiver are responding to treatment.
 14. The treatment provider shall provide a verbal or written summary of treatment and progress every sixty (60) days from the date of initiation of treatment to the JSW. Coordination shall occur between the treatment provider and the JSW to ensure that the summary of treatment and progress is received by the JSW prior to submission of the sixty (60) day court report.
 15. The JSW and DJJ shall document the youth and parent or caregiver's treatment progress in the youth's ICR.
- I. Treatment of Declared Juvenile Sexual Offenders in Out-of-Home Placement
1. If a youth is in an out-of-home placement, the treatment team shall address the sexual offending behavior in the ITP. All treatment plans shall be completed in accordance with DJJ Policy.
 2. Youth placed in foster care shall be provided juvenile sexual offender treatment by DJJ Mental Health Branch staff or by a DJJ approved private provider, as available. The JSW assigned the case management responsibilities shall initiate the referral for treatment to the Regional Psychologist or DJJ approved private provider, as available.
 3. The youth and parent or caregiver shall cooperate with the sexual offender treatment provider pursuant to KRS 610.160.
 4. Releases of information shall be obtained, as needed, from the youth and parent or caregiver to share appropriate information with collateral agencies, to include school systems and other individuals or agencies providing services.
 5. The treatment provider shall review the acknowledgement of HIPAA privacy practices and obtain all necessary signatures.
 6. The treatment provider shall inform the youth and parent or caregiver in writing of the confidentiality rights as established in KRS 635.527 and shall inform the youth and parent or caregiver of the role of the treatment team.

7. Treatment shall be provided to address the needs and risks of the juvenile. Reference DJJPP Chapter 3 (Individual Treatment Plan and Aftercare Plan).
 8. Reviews of the youth's progress shall be conducted every sixty (60) days regardless of the youth's placement as required by KRS 635.515 and a court report generated. This sixty (60) day court report shall include information about treatment received by the juvenile sex offender and parent or caregiver, assessment of the offender's current condition, and recommendations of the staff. The JSW shall prepare the report for the court incorporating the evaluation of how the youth and parent or caregiver are responding to treatment.
 9. The treatment provider shall provide a verbal or written summary of treatment and progress every sixty (60) days from the date of initiation of treatment to the JSW. Coordination shall occur between the treatment provider and the JSW to ensure that the summary of treatment and progress is received by the JSW prior to submission of the sixty (60) day court report.
 10. The JSW and DJJ treatment provider shall document the youth and parent or caregiver's treatment progress in the youth's ICR.
 11. For youth in out-of-home placement receiving treatment from a private treatment provider, the JSW shall schedule and document the review as outlined in policy.
- J. Auditing of cases shall be completed in compliance DJJPP Chapter 3 (Counseling Services) and DJJ Chapter 6 (Community Mental Health Operations).

Section IV – Victim Reunification and Family Reintegration

Applicability Statement: This Section IV shall be applicable to circumstances in which the victim is a member of the JSO's family. This Section IV additionally shall apply when the victim plans to live in the same home as the JSO or the same home that the JSO is expected to live in upon release from a residential placement.

- A. Victim safety shall be the primary consideration in any plan for contact or reunification. All contact shall be victim centered and based on victim need. Reunification with the victim or family reintegration shall not indicate completion of treatment.
- B. Victim reunification shall only be considered if the JSO, parent or caregiver, and victim are ready for the process. An assessment of readiness by both the victim and JSO's treatment providers' shall guide this process. For youth in residential placement, efforts shall be made to begin this process prior to discharge. However, victim's lack of readiness shall not impede the offender's return to the community setting.
- C. The clarification process begins with the JSO in treatment for abusive behaviors, progresses to an apology letter, and if appropriate, may move towards a highly structured and facilitated clarification session.
- D. A comprehensive healthy family living plan is one that identifies the strengths of the family as well as the risk factors, patterns, and warning signs of abuse and offers concrete boundaries for the family to maintain for everyone's safety.
- E. Even after family reintegration has begun, situations may arise in which there is a decision to terminate the process.
- F. Victim reunification may be addressed in aftercare planning and may be revised as appropriate through the course of treatment.
- G. The treatment team shall:
 - 1. Collaborate with the victim's therapist or advocate, guardian, custodial parent, foster parent, or guardian ad litem, in making decisions regarding communication, visits, and reunification counseling sessions;
 - 2. Support the victim's wishes regarding contact with the youth to the extent that it is consistent with the victim's safety and well-being; and
 - 3. Complete the healthy family living plan and youth self-regulation plan prior to the youth's reintegration into the home.
- H. If the treatment team recommends that the youth should have contact with the victim and there is an existing court order to have no contact with the victim, the JSW, after collaborating with the treatment team, shall schedule a court review to present a progress update on youth's treatment to request that the court order be modified or rescinded to allow contact.
- I. DJJPP Chapter 3 (Authorized Leave: Day Releases and Furloughs; Supervised Off-grounds Activities) shall be followed with regard to furloughs for a JSO, including the requirement that a JSO shall only be approved for release to the JSO's parent or caregiver for a day release, furlough, or emergency leave by the Treatment Team with notification to the Regional Director. Furlough time for a

declared JSO, prior to program completion, shall be considered on a case by case basis and shall not exceed ten (10) days.

Section V –Procedures for Reassessment and Criteria for Termination of Sex Offender Treatment

- A. Release from sex offender treatment shall not equate to release from commitment. All youth shall be subject to department policy and procedure regarding release from commitment.
- B. The criterion for termination of sex offender treatment shall be directly related to the completion of all of the sex offender specific treatment goals on the youth's ITP.
- C. In circumstances where the youth is receiving sex offender treatment in a residential facility, completion of the residential component may not equate to completion of the sex offender treatment program.
- D. Procedures for Reassessment:
 - 1. The treatment team shall meet and recommend termination of treatment for youth who have successfully completed the sex offender treatment goals on their ITP. In making this determination, the treatment team shall:
 - a. Consider all sources of collateral information; and
 - b. Assess and document evidence that the goals on the treatment plan have been met.
 - 2. For youth who are receiving sex offender treatment in the community and are nearing completion of sex offender treatment, a juvenile sexual offender reassessment shall be completed. If the sex offender treatment is being provided by a DJJ mental health staff the reassessment shall be completed by the mental health staff and approved by the Regional Psychologist. If the reassessment is completed by the Regional Psychologist it shall be reviewed and approved by the next line supervisor. If sex offender treatment is provided by an approved private provider, the private provider shall complete a juvenile sexual offender reassessment or an equivalent treatment summary noting the youth's progress in treatment, reasons for completing treatment, and current risk level to reoffend.
 - 3. Reassessment of Youth in a Youth Development Center
 - a. A reassessment shall be required for youth who are receiving sex offender treatment in a youth development center (YDC) under one of the following circumstances:
 - i. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment;
 - ii. The youth has completed sex offender treatment and will not be receiving further treatment in the community; or
 - iii. The youth is being placed on furlough. A reassessment shall not be required prior to furloughs where the youth is expected to return to the facility after the furlough. Reference DJJPP Chapter 3 (Authorized Leave: Day Release and Furloughs; Supervised Off-grounds Activities) and DJJPP Chapter 6 (Authorized Leave for Public Offenders, Juvenile Sexual Offenders, and Youthful Offenders in Placement).

- b. The juvenile sexual offender reassessment shall be completed by the treatment director or counselor. If the reassessment is completed by the counselor, the treatment director shall review and approve. If the reassessment is completed by the Treatment Director it shall be reviewed by the Regional Psychologist or a board approved clinical supervisor.
 - 4. Reassessment of Youth in a Group Home
 - a. A reassessment shall be required for youth who are receiving sex offender treatment in a group home under one the following circumstances:
 - i. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment;
 - ii. The youth has completed sex offender treatment and will not be receiving further treatment in the community; or
 - iii. The youth is being placed on furlough. A reassessment shall not be required prior to furloughs where the youth is expected to return to the facility after the furlough. Reference DJJPP Chapter 3 (Authorized Leave: Day Release and Furloughs; Supervised Off-grounds Activities) and DJJPP Chapter 6 (Authorized Leave for Public Offenders, Juvenile Sexual Offenders, and Youthful Offenders in Placement).
 - b. The juvenile sexual offender reassessment shall be completed by the counselor or mental health staff and shall be reviewed and approved by the Regional Psychologist.
 - 5. The JSW shall request a reassessment or discharge summary for youth who are receiving sex offender treatment in a private childcare, therapeutic foster care, or a hospital setting under one the following circumstances:
 - a. The youth is nearing discharge from the facility to return to the community on conditions of supervised placement for continued sex offender treatment; or
 - b. The youth has completed sex offender treatment and will not be receiving further treatment in the community.
 - 6. Reassessments for YOs who are declared sex offenders shall not be required prior to the youth's final sentencing hearing unless requested by the court.
- E. The reassessment shall contain updates from the initial risk assessment of the following required content:
 - 1. Identifying Information;
 - 2. Assessor;
 - 3. Reason for Referral;
 - 4. Data Sources;
 - 5. Assessment Interview and Behavior Observation;
 - 6. Legal History;
 - 7. Family History;
 - 8. Social History and Peer Relations;
 - 9. Recent Behaviors;
 - 10. Education and Vocation;
 - 11. Substance Use and Treatment History;
 - 12. Medical and Mental Health History;

13. Treatment Progress;
14. Risk Assessment Results; and
15. Summary and Recommendations.

F. All juvenile sexual offender reassessments shall be sent to the youth's JSW.

G. Process for Termination of Juvenile Sexual Offender Treatment

1. The JSW shall complete the Request to Release from Sex Offender Treatment on all declared JSO's, regardless of placement, and submit through the chain of command. A copy of the juvenile sexual offender reassessment or private provider treatment summary shall be attached.
2. The Division Director of Community and Mental Health Services shall give final approval to release a declared JSO from sex offender treatment, regardless of placement.
3. Upon receiving final approval, the JSW shall request the committing court to re-docket the youth's case for review per KRS 635.515(7). The court review shall be requested sixty (60) days prior to the recommended date of release from treatment.
4. Release from sex offender treatment shall not equate to release from commitment. All youth shall be subject to department policy and procedure regarding release from commitment.
5. Termination without completion of the sex offender treatment shall not be determined by the treatment team. When the treatment team has determined that a youth is not making progress and will not benefit from continued sex offender treatment, a report shall be forwarded through the appropriate chain of command, to include the Division Director of Community and Mental Health Services, regarding the circumstances. In these situations, the Division Director of Community and Mental Health Services, in consultation with the Chief of Mental Health Services, shall direct an appropriate course of action for each request.

Section VI - Criteria for Requesting Fourth Year of Treatment

- A. Prior to a request for a fourth year of sex offender treatment a comprehensive psychosexual risk assessment shall be completed by the treatment provider and reviewed by the treatment team.
- B. For youth in out-of-home placement, the treatment team, including the JSW, shall determine if the youth is in need of a fourth year of sex offender treatment.
- C. For youth residing in the community, the JSW shall initiate the request for a fourth year of sex offender treatment after consultation with appropriate treatment providers.
- D. A written request for a fourth year of treatment shall not be made unless one or more of the following factors are present:
 - 1. Persistent and recent refusal to comply with treatment requirements;
 - 2. Recent commission of a new sex offense or recent verbalization of intent to reoffend;
 - 3. Recent absent without leave (AWOL) from out-of-home placement; or
 - 4. Youth recently exhibiting high risk sexually acting out behavior while in treatment.
- E. The following process shall be utilized when requesting a fourth year of sex offender treatment for youth in out-of-home placement:
 - 1. The youth's assigned residential counselor shall complete a written request and forward it through the chain of command to the Deputy Commissioner of Program Operations, or designee, for consideration. The request shall specify the basis for the need for a fourth year of sex offender treatment consistent with the requirements set forth in DJJPP Chapter 8 (Treatment Program for Declared Juvenile Sexual Offenders) and the youth's treatment needs.
 - 2. If the request is approved at the Deputy Commissioner level in consultation with the Chief of Mental Health Services, the residential counselor shall notify the DJJ Office of Legal Counsel and request a motion to be filed in the committing or sentencing court requesting the fourth year of sex offender treatment. The JSW shall assist in presenting the request to the committing judge for consideration. The youth's attorney, including the attorney from the Juvenile Post Disposition Branch if represented by the Department of Public Advocacy (DPA), shall also be provided notice of the motion in accordance with court rules.
- F. The following process shall be utilized when requesting a fourth year of sex offender treatment for youth residing in the community:
 - 1. The JSW, after consultation with the JSDS, shall determine if the youth is in need of a fourth year of sex offender treatment.
 - 2. The JSW shall complete a written request for a fourth year of sex offender treatment and forward it through the chain of command to the Deputy Commissioner of Community and Mental Health Services or designee for consideration. The request shall specify the basis for the need for a fourth year of sex offender treatment consistent with the requirements set forth in DJJPP Chapter 8 (Treatment Program for Declared Juvenile Sexual Offenders) and the youth's treatment needs.

3. If the request is approved at the Deputy Commissioner level in consultation with the Chief of Mental Health Services, the JSW shall notify the DJJ Office of Legal Counsel requesting a motion to be filed in the committing or sentencing court requesting the fourth year of sex offender treatment. The youth's attorney shall also be provided notice of the motion in accordance with court rules.

Section VII - Utilization of Polygraph Examinations

Polygraph examinations, if used, shall be performed in accordance with DJJPP Chapter 8 (Polygraph Examinations).

Section VIII – Youthful Offender Sexual Offender Registry

- A. The JSW shall complete the Sex Offender Duty to Register Notification Form P227 as required by 502 KAR 31:020 on any YO who pleads guilty or is convicted of a “Sex Crime” as defined in KRS 17.500(8); a “criminal offense against a victim who is a minor” as defined in KRS 17.500(3)(a), or is required to register pursuant to KRS 17.510. The JSW shall ensure that the offender signs the form.
- B. The Sex Offender Duty to Register Notification Form shall be forwarded to the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road Frankfort, KY 40601 and to the sentencing court with the Presentence Investigation Report. See KRS 17.510(3).
- C. Information on the Sex Offender Duty to Register Notification Form shall be verified by the Presentence Investigation Report, if available.
- D. The Superintendent or designee of the DJJ program in which the youth is housed shall inform any YO convicted of offenses outlined in KRS 17.500(3)(a) or KRS 17.500(8) or required to register pursuant to KRS 17.510 of the duty to register and shall require the youth to read and sign the Sex Offender Duty to Register Notification Form P227 provided for that purpose, prior to his release, pursuant to KRS 17.510(3). A copy of the form shall be maintained in the youth’s file and the original shall be sent, along with a copy of the original at the time of sentencing, to the Department of Juvenile Justice Administrator of the Sex Offender Tracking System for forwarding to the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road Frankfort, KY 40601.
- E. On or before the date of the offender’s release by the court, the parole board, the cabinet, or any detention or residential facility, the registrant shall register with the appropriate local probation and parole office in the county in which he or she intends to reside as required by KRS 17.510 (2).
- F. If the JSW determines that the offender did not comply with the registration requirements, the worker shall notify the Kentucky State Police (KSP) Sex Offender Registry (SOR) Unit, 1266 Louisville Road, Frankfort, KY 40601. Documentation of the notification shall be maintained in the youth’s file and shall be sent to the DJJ Sex Offender Tracking System Administrator.



The "ERASOR"

*Estimate of Risk of Adolescent Sexual Offense Recidivism
Version 2.0*

February 2001

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The guidelines contained in this report were developed by the authors in the course of their duties at the SAFE-T Program. Anyone choosing to use or adopt the risk assessment guidelines outlined herein does so on the sole basis of their responsibility to judge their suitability for their own specific purposes. The Ontario Ministry of Community & Social Services, its employees, agents, servants and the authors neither assume nor accept any responsibility or legal liability for any injury or damages whatsoever resulting from the use of The *ERASOR* and the guidelines outlined herein.

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There is considerable controversy concerning the best approach to conducting risk assessments with sexual offenders. Everyone agrees that evaluators should consider valid risk factors, and that evaluations based on multiple sources of information are more likely to be reliable than those based on a single source (particularly when that source is the offender). Disagreement arises, however, on the best method for combining risk factors into comprehensive evaluations. Many of these debates will remain active pending future research. (Hanson [for the Association for the Treatment of Sexual Abusers], 2000, pp. 4-5).

Introduction

In addition to treatment planning, one of the goals of a comprehensive adolescent sexual offender assessment is to make some determination regarding the risk of future sexual offenses. In a recent publication of the Association for the Treatment of Sexual Abusers regarding guidelines for risk assessment, Hanson (2000) noted that formal sexual offense risk predictions are required for a number of reasons including sentencing, conditional release, and decisions regarding family reunification.

Boer, Hart, Kropp, and Webster (1997) and Grubin (1999) point out that there are two traditional approaches to the prediction of future sexual violence: unstructured clinical prediction and actuarial assessment. In forming unstructured clinical predictions, professionals utilize an accumulation of their anecdotal experiences to make a determination of risk level. Although there is evidence that unstructured clinical judgements of risk for future sexual violence are, on average, slightly better than chance (Hanson & Bussière, 1998), there are a number of serious concerns with this approach (see Monahan, 1995, for a complete critique). For example, it is often very difficult to ascertain just how clinical risk ratings are made and, as such, these predictions are difficult to question, challenge, or support. It is also likely that other raters using the same method would end up with different risk ratings for the same individuals. Even if different raters arrive at the same overall risk rating, it is likely that they will be based on different factors. The most serious concern, of course, is the poor level of accuracy. Boer et al. (1997) comment, however, that the main advantage of the unstructured, or "professional judgement", method is its flexibility to consider and combine a variety of potential risk factors.

In actuarial risk assessments, on the other hand, a fixed number of risk factors are evaluated using a structured and objective rating system. Scores for each risk factor are summed, and this typically yields an overall risk score that can be linked to a probabilistic statement of risk (e.g., 30% chance of a sexual reoffense within the next 5 years). The development of most actuarial risk assessment tools is based on research that links recidivism to the variables of interest. Some of the benefits to actuarial risk assessment include a high degree of agreement between different raters, ease of administration and scoring, retrospective empirical support for each risk factor considered, and the ability to test the accuracy, or predictive validity, of the numerical algorithms that are proposed to predict risk.

Despite the many advantages of the actuarial method (see Loza & Dhaliwal, 1997), there are a number of potential drawbacks. One of the most significant limitations of the actuarial method is the fact that no actuarial instrument could possibly include *all* potential risk indicators

(Hanson, 2000). Another criticism is that many of the variables included in existing actuarial systems are static, or "fixed" (such as gender), and are of little use to those who are devising a treatment program to manage risk of sexual reoffending. Once deemed "high risk" using such static factors, an offender will necessarily always remain at high risk.

A recent development in the prediction of sexual recidivism is a third method that Hanson (1998) has called the empirically-guided clinical judgement. This is the approach used by Boer et al. (1997) in the development of the Sexual Violence Risk-20 (SVR-20). In this approach, raters base their predictions on a fixed list of risk factors that have been suggested by existing research and professional opinion. Unlike actuarial scales, there are no fixed rules for tallying risk scores. As such, the overall determination of risk remains a clinical judgement, and Hanson (2000) noted that this is one of the most significant limitations of this approach. However, the advantage of empirically-guided clinical judgement in comparison to clinical prediction is that there is the promise of higher accuracy given the scientific evidence to support the risk factors being evaluated. Furthermore, the empirically-guided approach is more systematic and should lead to better agreement among professionals (Boer et al., 1997).

To date, most research regarding the prediction of sexual recidivism has been based on retrospective studies of *adult* male sexual offenders. Indeed, Hunter and Lexier (1998) recently noted that clinicians making risk predictions regarding adolescent sexual offenders must rely on "unproved theoretical assumptions about factors that increase risk of dangerousness" (p. 344). Although there are a number of existing risk-prediction checklists or guidelines for adolescent sexual offenders (Bremer, 1998; Calder, Hanks, & Epps, 1997; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986), there are no empirical data regarding their validity.

Prentky, Harris, Frizzell, and Righthand (2000) recently published an actuarial scale for assessing risk with juvenile sexual offenders. In their investigation, they used 12-month follow-up data from a group of 75 offenders, aged 9-20 years. The authors note that the number of sexual recidivists was too low (likely due to the brevity of the follow-up period) to warrant any statistical comparisons between sexual reoffenders and sexual non-reoffenders. Therefore, there is currently no empirical support regarding the use of this measure to predict sexual recidivism for adolescents. Prentky et al. (2000) acknowledged that this scale represents an initial contribution to the field of risk prediction for juvenile sexual offenders and that further refinement and data collection is necessary to develop a valid scale.

We decided to address the need for an empirically-guided clinical judgement methodology to predict adolescent **sexual** recidivism. The result was The Estimate of Risk of Adolescent Sexual Offense Recidivism (The *ERASOR* [Version 1.2]; Worling & Curwen, 2000b). The present version of The *ERASOR* (2.0) replaces the previous manuscript.

Purpose of The *ERASOR*

The *ERASOR* is designed to assist evaluators to estimate the risk of a sexual reoffense ONLY for individuals aged 12-18 who have previously committed a sexual assault. Those interested in predicting *nonsexual* criminal reoffending for adolescents are encouraged to use established and empirically validated instruments such as the Youth Level of Service/Case Management Inventory (Hoge & Andrews, 1994). Those interested in predicting sexual recidivism for adults are encouraged to use instruments such as

the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR; Hanson, 1997), the Sex Offender Risk Appraisal Guide (SORAG; Quinsey, Harris, Rice, & Cormier, 1998), or the Static-99 (Hanson & Thornton, 1999) and to review the informational package regarding risk assessment published by the Association for the Treatment of Sexual Abusers (Hanson, 2000). Those interested in predicting the risk of sexual violence for children under 12 with sexual behaviour problems should consult the body of literature regarding this issue.

The *ERASOR* was developed in a similar fashion to the SVR-20 (Boer et al., 1997) and we are most grateful to the work that was done by the authors and reviewers of that document. As Boer et al. (1997) stated in the SVR-20, it must be stressed that the factors suggested in The *ERASOR* are certainly not exhaustive as there are, in many cases, unique risk factors specific to the particular individual being assessed. Furthermore, the guidelines provided in this document are based on the scientific knowledge to date; therefore, it is *certain* that, with the advancement of knowledge, new risk factors will be identified, and some factors herein will no longer be supported.

Using The *ERASOR*

We would suggest that when using The *ERASOR*, evaluators follow the guidelines suggested by Boer et al. (1997) [and adapted and augmented slightly herein]:

1. Evaluators using The *ERASOR* to make decisions regarding an adolescent's placement or treatment should have the following: (1) a high level of training and expertise regarding the assessment of adolescents and their families, (2) a high level of training and expertise regarding the etiology, assessment, and management of sexual violence, and (3) familiarity with the existing research regarding adolescent sexual recidivism, including the published follow-up research cited in this document (see Table 1 on page 39 for a listing of some of the pertinent research).
2. Evaluators should assess multiple domains of the offender's functioning, including sexual (e.g., sexual arousal, sexual attitudes, sexual preoccupation), intrapersonal (e.g., affective expression, impulsivity), interpersonal (e.g., social involvement, aggression), familial (e.g., parent-child relationships, family distress), and biological (e.g., neurological, physical health).
3. Evaluators should use multiple methods of data collection to form opinions regarding risk. Methods could include clinical interviews, psychological tests, behavioural observation, medical examinations, and reviews of previous case records and reports. At a minimum, evaluators should collect information directly from the offender AND from official records regarding the adolescent's sexual offense(s).
4. Evaluators should collect information from multiple sources such as the offender, the victim(s), the police, family, friends, and other mental health professionals who are familiar with the offender and his/her family. At a minimum, evaluators should collect information from the offender, adults responsible for the adolescent's care, and official records regarding the adolescent's sexual offense(s).
5. Evaluators should collect information regarding both static (historic and unchangeable) and dynamic (variable and potentially changeable) factors. Although research with adult sexual offenders has demonstrated that static factors are often the best predictors over lengthy time

intervals, there is promise that a number of dynamic factors will be supported in future research (Hanson, 2000). Furthermore, information regarding dynamic factors will assist in treatment planning for those who will be assisting the offender to manage risk.

6. Evaluators should always be cognizant of the validity of the information that they are using in forming risk predictions and should state any reservations or qualifications in their reports. It may also be desirable for multiple evaluators to participate in the formulation of an estimate of risk—perhaps independently at first followed by a discussion of the findings.
7. Evaluators should recognize that risk assessments will become obsolete after the passage of time and/or following a change in ANY of the risk factors that were assessed.

The 25 risk factors included in The *ERASOR* fall into 5 categories (please refer to Coding Form): (1) Sexual Interests, Attitudes, and Behaviours, (2) Historical Sexual Assaults, (3) Psychosocial Functioning, (4) Family/Environmental Functioning, and (5) Treatment. It is important to note that there is also provision for an "Other Factor" when case-specific risk factors should be catalogued. For example, it may be the case that a particular adolescent presents greatest risk when high or drunk, and that current use of non-prescription drugs and alcohol would be important to rate. Similarly, if an adolescent states that they are very likely to reoffend sexually, this should be taken into consideration.

Deriving the Final Estimate of Risk

Given that there is currently no empirical support for a specific algorithm for combining risk factors to predict adolescent sexual recidivism, clinical judgement is necessary to determine the overall level of risk (i.e., "low", "moderate", or "high"). It is anticipated that there will be a general relationship between the number of high-risk factors and the rating of risk such that more high-risk indicators suggest higher risk. However, as Boer et al. (1997) observe, the final decision will be more dependent on the combination of risk factors rather than just the number. Furthermore, Boer et al. (1997) suggest that it is possible that the presence of a single risk factor—such as the offender's stated intentions to reoffend—could be indicative of high risk. For example, we (Worling and Curwen, 2000a) found that self-reported sexual interest in younger children was a significant and robust predictor of sexual recidivism.

Communicating Risk Estimates

Any prediction of future sexual recidivism risk should be limited and qualified. The following guidelines are suggested when communicating estimates of sexual recidivism for adolescent sexual offenders. These guidelines have been adapted from those listed in the SVR-20 (Boer et al., 1997) and include additional suggestions (Worling, 2000).

1. **Evaluators should inform their audience of the scientific limitations of their risk predictions.** Despite the obvious appeal of actuarial risk assessment devices, there are currently no empirical data to support the predictive validity of any such tool for adolescent sexual offenders. Many of the factors used in The *ERASOR* are included because of some agreement in professional clinical opinion and at least some research support based on

retrospective studies with adolescent and/or adult sexual offenders. It is important to inform the audience that the overall risk rating is a clinical opinion based on the scoring guidelines outlined in The *ERASOR*.

2. **Evaluators should note that their estimates of risk of sexual recidivism are time limited.** Most of the retrospective research that has been used to support the factors included in The *ERASOR* is based on follow-up data of 3 years or less, and no study used a mean follow-up period beyond 6 years. Given this fact, plus the rapid developmental changes (i.e., social, physical, familial, sexual, etc.) during adolescence, it will be important to note that any risk predictions are strictly time limited and should be repeated after either a fixed time interval (such as 2 years) or following significant change in one or more of the risk factors.
3. **Evaluators should justify risk estimates by referring to the presence or absence of specific high-risk factors.** It would be most helpful to comment on the specific reasons why an offender is at a particular level of risk. Of course, these details would also assist with treatment planning to manage risk.
4. **Evaluators should make sexual recidivism risk predictions as specific as possible.** For example, if it is determined that an adolescent presents a high degree of risk for continued sexual assaults against younger males, this should be noted in the communication of findings. Of course, if it is not possible to make specific predictions regarding the next likely sexual offense, evaluators should not feel compelled to "guess" without supporting data.
5. **Evaluators should list circumstances that might exacerbate the offender's risk of reoffending sexually in the short-term.** In other words, it would be helpful—wherever possible—to describe situations that could be warning signs for those working with the offender. For example, proximity to young females, cancelled family visits, or availability of pornography may be issues that could be noted if they were anticipated to increase risk for a certain offender.
6. **Evaluators should list strategies that they believe would be helpful in managing the offender's risk.** In addition to possible therapeutic interventions, strategies may include recommendations regarding place of residence, community supervision, access to pornography, timing of family reunification, etc.

An example abbreviated risk-prediction statement that incorporates the guidelines listed above is provided on the next page.

Example Abbreviated Risk Statement

There are presently no empirically validated, actuarial instruments that can be used to accurately estimate the risk of adolescent sexual reoffending. Based on the best available research data and consensus in professional clinical opinion, however, a number of high-risk factors have been identified in the literature. The Estimate of Risk of Adolescent Sexual Offense Recidivism (The *ERASOR*: Worling & Curwen, 2001) summarizes the available research and expert clinical opinion and this instrument was used to estimate the risk of sexual reoffense for this client.

At the present time, Terry presents a high degree of risk of sexual reoffending as the following high-risk factors were identified: sexual interest in younger children, attitudes supportive of sexual offending (i.e., that children will not be "harmed" by sexual interactions with a teen), the selection of a stranger victim, a number of prior sexual offences, continued sexual offending despite adult sanctions (criminal charge) for a prior assault, recent interpersonal aggression, problematic parent-child relationship, and incomplete sexual-offense-specific treatment. Given that Terry has only been known to commit offenses against younger females, it is likely that the high level of risk is limited to younger females.

Risk would best be managed through a combination of sexual-offense-specific treatment aimed at altering the potentially changeable risk factors listed above such as Terry's deviant sexual arousal and attitudes, relationships with parents, and the use of interpersonal aggression. Although Terry was able to demonstrate some awareness of personal high-risk indicators, it is likely that sexual-offense-specific treatment will provide Terry with a better awareness of risk indicators and techniques that can be used to avoid further sexual offenses.

Given the rapid developmental changes during adolescence, the potential for change in a number of these risk factors, and the fact that much of the supporting research is based on follow-up data of less than 3 years, it is essential to note that this estimate of risk should be re-evaluated after a period of **at most** 2 years or following significant social, environmental, familial, sexual, affective, physical, or psychological change.

ERASOR Risk Factors

The following pages outline the rationale and coding procedures for the 25 risk factors included in The *ERASOR*. For ease of scoring, a 10-page Coding Form is included; however, it is essential that evaluators are familiar with the contents of the entire *ERASOR* manual. The 10-page Coding Form could be photocopied for each adolescent. Finally, it is important to stress that evaluators should never **ONLY** use the summary sheet (page 10 of the Coding Form) when formulating risk estimates.

1. Deviant sexual interests (children, violence, or both).

Adolescents who are sexually aroused by younger children and/or sexual violence are more likely to be at risk of committing subsequent sexual offenses. In a recent retrospective study of adolescent sexual offenders, we (Worling & Curwen, 2000a) found that self-reported sexual interest in children—including past or present sexual fantasies of children, child-victim grooming behaviours, and penetrative sexual assault activities with children—was a significant predictor of sexual reoffending. Schram, Malloy, and Rowe (1992) also found that those adolescent offenders rated by clinicians as most likely to have deviant sexual interests were significantly more likely to reoffend sexually. Authors of existing risk-prediction checklists/guidelines for adolescents have commented that those adolescent sexual offenders who display sexual interest in young children and/or sexual violence are at higher risk for sexual recidivism (Calder et al., 1997; Epps, 1997; Lane, 1997; Ross & Loss, 1991).

Deviant sexual interest—particularly sexual interest in children—was found to be the variable most related to subsequent sexual reoffending in a recent meta-analysis of retrospective studies of adult male sexual offenders (Hanson & Bussière, 1998). The presence of deviant sexual arousal has also been listed as a high-risk factor for adult male sexual offenders in actuarial risk-prediction tools such as the Sex Offender Risk Appraisal Guide (SORAG; Quinsey et al., 1998), and the Minnesota Sex Offender Screening Tool—Revised (MnSOST-R; Epperson, Kaul, & Hesselton, 1998), and in the Sexual Violence Risk-20 (SVR-20; Boer et al., 1997).

Coding

<input type="checkbox"/> Present <input type="checkbox"/> Children <input type="checkbox"/> Violence	<ul style="list-style-type: none"> At any time within the past 6 months, the adolescent has reported or demonstrated sexual arousal to thoughts/images of children under 12 years of age (and children who are at least 4 years younger than the adolescent), OR Sexual assaults—within the past year—against 2 or more children under 12 years of age (and children who are at least 4 years younger than the adolescent), OR At any time within the past 6 months, the adolescent has reported or demonstrated sexual arousal to sexual violence (excessive physical violence, threats of death or physical pain, use of weapons), OR Sexual assaults—within the past year—against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Possibly or Partially Present <input type="checkbox"/> Children <input type="checkbox"/> Violence	<p>Possible or partial evidence that the adolescent</p> <ul style="list-style-type: none"> Has reported or demonstrated deviant sexual arousal to prepubescent children, sexual violence, or both, at any time within the past 6 months, OR Within the past year, has committed sexual assaults against 2 or more prepubescent children or sexual assaults against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Not Present	<ul style="list-style-type: none"> Adolescent has reported AND demonstrated NO sexual arousal to thoughts and/or images of prepubescent children, sexual violence, or both during the past 6 months, OR Within the past year, the adolescent has NOT committed sexual assaults against 2 or more children, or sexual assaults against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Unknown	<p>Insufficient information to support a decision regarding this risk factor.</p>

There are considerable scientific and ethical concerns regarding the use of penile plethysmography (PPG) with adolescents (Hunter & Lexier, 1998; Worling, 1998). Information regarding this factor can be obtained through clinical interviews, observation, psychological testing, and a review of collateral reports. Although it is *generally* considered important to ensure that there is at least a 4-year age difference between the adolescent and the children who are the objects of the sexual thoughts/images, factors such as the differences in size and level of emotional maturity between the offender and the child are also important to consider.

2. Obsessive sexual interests / Preoccupation with sexual thoughts.

Adolescent sexual offenders who demonstrate obsessive sexual interests and who are preoccupied with sexual thoughts, behaviours, or gestures are most likely at greater risk of further sexual assaults. Although there is no empirical support for the inclusion of this risk factor with adolescents at this time, this may be the result of the fact that it has yet to be examined in research.

Authors of existing risk-assessment checklists/guidelines for adolescent sexual offenders have noted the need to assess the presence of sexual preoccupation (Epps, 1997; Lane, 1997; Prentky et al., 2000; Steen & Monnette, 1989), compulsive ideation regarding past offenses (Perry & Orchard, 1992), and compulsive, deviant masturbatory fantasies (Ross & Loss, 1991; Wenet & Clark, 1986) when assessing risk to reoffend sexually.

Sexual preoccupation is included in the Sex Offender Need Assessment Rating (SONAR; Hanson & Harris, 2000), an actuarial risk-prediction tool for adult sexual offenders as the authors have noted a relationship between sexual recidivism and sexual preoccupation.

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has demonstrated obsessive sexual interests/preoccupation with sexual thoughts as evidenced by any of the following: <ul style="list-style-type: none"> • Unusually frequent masturbation • Unusually frequent sexual thoughts, comments, gestures, or behaviours • Unusually frequent use of pornography (or other textual, pictorial, or auditory materials considered erotic by adolescent) • Unusually frequent engagement in sexual fantasy • Excessive use of sexual behaviours/fantasies to cope with negative affect (boredom, loneliness, frustration, sadness), anger, or problematic situations.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has been preoccupied with sexual thoughts, behaviours, fantasies, images, or gestures at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT demonstrated obsessive sexual interests or preoccupation with sexual thoughts, behaviours, fantasies, images, or gestures during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

3. Attitudes supportive of sexual offending.

Adolescents with a history of sexual offenses who believe that sexual assaults are "invited", "desired", "harmless" or otherwise "welcomed" by victims are most likely at higher risk to continue committing sexual assaults. Although there are few empirical data to support the inclusion of this factor at present, this may be a result of the fact that it has rarely been studied in research. In one study, Kahn and Chambers (1991) found that those adolescents who blamed their victims were significantly more likely to have subsequent convictions for sexual assault. Furthermore, authors of existing risk-assessment checklists/guidelines for adolescent sexual offenders note that assault-supportive attitudes such as victim blame and the belief that sexual assaults are not wrong or harmful are indicators of higher risk (Calder et al., 1997; Epps, 1997; Perry & Orchard, 1992; Prentky et al., 2000).

In a recent investigation of adult male sexual offenders, Hanson and Harris (1998) found that attitudes supportive of sexual offending were significantly related to sexual recidivism, and they included this variable in the SONAR (Hanson & Harris, 2000). In a recent publication by the Association for the Treatment of Sexual Abusers, Hanson (2000) noted that this particular factor is a promising dynamic (potentially changeable) risk-prediction variable for adult male sexual offenders. Boer et al. (1997) also considered attitudes that support or condone sexual offenses as high-risk markers on the SVR-20 for adult sexual offenders.

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has endorsed ANY of the following attitudes: <ul style="list-style-type: none"> Sexual interactions with children under 12 years of age are not harmful to the child; are desired by the child; are often initiated by children; should be legalized; are just displays of affection; or are educational for the child, OR Forced sexual interactions with peers or adults are not harmful; are desired; are enjoyable; are initiated by the victim's style of dress or behaviour; or that disclosures of forced sexual interactions are usually fabricated.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has endorsed attitudes supportive of sexual offending at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT endorsed attitudes supportive of sexual offending during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information regarding the offender's sexual attitudes may be available from psychological test results, clinical interviews, observation, or collateral reports.

4. Unwillingness to alter deviant sexual interests/attitudes.

Adolescents who are unwilling to change their deviant sexual thoughts, interests, or attitudes are likely at higher risk of reoffending sexually. Resistance to "give up" deviant sexual interests or attitudes may reflect the strength of these interests or attitudes, the lack of hope in positive change, or the current lack of interest in more appropriate sexual thoughts/fantasies. Although there is no empirical support for the inclusion of this variable from research with either adults or adolescents, this may be the result of the fact that it has never been studied. Authors of existing risk-assessment checklists/guidelines for adolescent sexual offenders have suggested that offenders who are resistant to treatment are at higher risk to reoffend sexually (Bremer, 1998; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989). Prentky et al. (2000) noted that offenders who lack internal motivation to change are at higher risk.

While sexual offenders are likely motivated to drop out of treatment for a variety of reasons, there is presently ample evidence to suggest that adult males who drop out of sexual offender treatment are at higher risk for subsequent sexual offenses (e.g., Hanson & Bussière, 1998). In their list of high-risk factors on the SVR-20, Boer et al. (1997) stated that those men who display a negative attitude toward treatment are at higher risk to reoffend sexually.

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has been unwilling to alter or "give up" the: <ul style="list-style-type: none"> Deviant sexual interests that were rated as "Present" or "Possibly or Partially Present" in #1 above OR Attitudes supportive of sexual offending that were rated as "Present" or "Possibly or Partially Present" in #3 above
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has been unwilling to alter the: <ul style="list-style-type: none"> Deviant sexual interests that were rated as "Present" or "Possibly or Partially Present" in #1 above OR Attitudes supportive of sexual offending that were rated as "Present" or "Possibly or Partially Present" in #3 above
<input type="checkbox"/> Not Present	<ul style="list-style-type: none"> During the past 6 months, the adolescent HAS been willing to alter deviant sexual interests (#1 above) or attitudes supportive of sexual offending (#3 above), OR Neither #1 nor #3 above were coded as "Present" or "Possibly or Partially Present"
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Non-compliance with treatment, or failing to attend, does **not** necessarily constitute evidence of unwillingness to "give up" deviant sexual interests or attitudes. Likewise, attendance at therapy or compliance with treatment does **not** necessarily imply the absence of this factor.

Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

5. Ever sexually assaulted 2 or more victims.

Adolescents who have committed sexual offenses against 2 or more victims are most likely at higher risk of reoffending than those adolescents who have committed offenses against a single victim. Research regarding this factor is quite consistent. Specifically, Rasmussen (1999) found that the number of female victims was significantly related to sexual reoffenses. Schram, Malloy, and Rowe (1992) found that adolescents with at least one prior conviction for a sexual assault were significantly more likely to reoffend sexually. Långström and Grann (2000) found that, after an average follow-up period of 5 years, adolescents in Sweden with 2 or more prior victims were significantly more likely to be reconvicted for a subsequent sexual crime. Although we (Worling & Curwen, 2000a) initially found that there was no significant relationship between *total* number of victims and subsequent sexual recidivism, further analyses revealed that those adolescents in our study with 2 or more victims were significantly more likely to reoffend sexually (Worling, in press). Available risk-prediction checklists/guidelines for adolescent sexual offenders suggest that numerous past sexual offenses is a high-risk marker (Bremer, 1998; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986).

In retrospective studies with adult male sexual offenders, the number of previous sexual offenses is highly related to later sexual reoffending (Hanson & Bussière, 1998). Actuarial risk-prediction tools for adult male sexual offenders include some assessment of the number of previous sexual offenses (Epperson et al., 1998; Hanson, 1997; Hanson & Thornton, 1999; Quinsey et al., 1998). The SVR-20 (Boer et al., 1997) also includes a measure of the frequency of past sexual offending as a predictor of sexual recidivism.

Coding

<input type="checkbox"/> Present	Adolescent has intentionally sexually assaulted 2 or more victims.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has intentionally sexually assaulted 2 or more victims.
<input type="checkbox"/> Not Present	Adolescent has intentionally sexually assaulted 1 victim.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Sexual offenses include both contact and noncontact (e.g., exhibitionism) behaviours, and it is not necessary that the adolescent was detected or sanctioned (e.g., received criminal charges) to be coded as present.

In general, one should code sexual behaviours that occurred at or beyond age 12. Sexually aggressive behaviours that occurred between the ages of 8 and 12 should be coded with extreme caution, and they should ONLY be considered for this factor if (a) they occurred within the past 2 years, or (b) there has been a fairly consistent pattern up to the time of the most recent sexual offense—that is, at least one occurrence of the sexual aggression in question every 2 years.

The term “intentionally” is used here to identify those offenders who consciously target 2 or more specific victims. For example, an offender who was exposing to a specific peer-age female may have also been seen by another person. In this case, this factor would not be coded as present.

It is essential to examine all sources of information including victim-impact statements, police reports, clinical interviews, and other collateral data.

6. Ever sexually assaulted same victim 2 or more times.

Adolescents who have committed multiple sexual offenses against the same victim are most likely at higher risk of reoffending than those adolescents who have committed a single offense against a victim. This factor is closely related to #5 above (2 or more victims) except that the frequency of sexual offending here is related to repeated sexual assaults against the same victim. Most research with both adolescents and adults regarding the frequency of sexual offenses is related to the number of previous charges; without specific reference as to whether this refers to the actual number of offenses or the number of victims. As such, there is currently little empirical support for this factor at this time. Recall, however, that available risk-prediction checklists/guidelines for adolescent sexual offenders suggest that numerous past sexual offenses is a high-risk marker (Bremer, 1998; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark). It will be important for researchers to determine how the two measures of frequency of offending (i.e., number of victims and number of offenses) contribute to the prediction of future risk.

Coding

<input type="checkbox"/> Present	Adolescent has sexually assaulted the same victim on 2 or more occasions.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has sexually assaulted the same victim on 2 or more occasions.
<input type="checkbox"/> Not Present	Adolescent has NEVER sexually assaulted the same victim on more than 1 occasion.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

It is essential to examine all sources of information including victim-impact statements, police reports, clinical interviews, and other collateral data.

7. Prior adult sanctions for sexual assault(s).

Adolescents who continue to commit sexual offenses after they have been detected and warned by police, parents, residential staff, or teachers, for example, are more likely at risk of continued sexual aggression towards others. It is likely that there are some adolescents who will discontinue sexually offending once their behaviour has been brought to the attention of an adult in a position of authority. This may be a result, at least partially, of the shame and embarrassment connected with the adolescent's sexual behaviour. Of course, there are also many adolescents who continue to commit sexual offenses despite interventions by adults (Worling & Curwen, 2000a). When an adolescent continues to commit sexual offenses despite being detected and sanctioned by an adult, this may be reflective of more deviant sexual interests (see #1), obsessive sexual interests (see #2), or attitudes supportive of sexual offending (see #3). Additionally, adolescents who continue to commit sexual offenses following adult sanctions may be more resistant to altering deviant sexual interests/attitudes (see #4).

There is little empirical support for this factor at the present time, as researchers have yet to examine the impact of prior adult sanctions on subsequent adolescent sexual recidivism. In available risk prediction checklists/guidelines for adolescents, it has been noted that prior attempts to provide treatment is a marker of higher risk (Epps, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1990; Wenet & Clark, 1986) as is a history of a prior criminal charge for a sexual offense (Prentky et al., 2000; Ross & Loss, 1991).

In retrospective studies with adult male sexual offenders, a history of prior legal sanctions (i.e., charges or convictions) is highly related to later sexual reoffending (Hanson & Bussière, 1998). Actuarial risk-prediction tools for adult male sexual offenders include some assessment of the presence of prior charges or convictions for sexual offenses (Epperson et al., 1998; Hanson, 1997; Hanson & Thornton, 1999; Quinsey et al., 1998). Researchers have yet to examine the impact of non-legal sanctions on the sexual recidivism of adults.

<input type="checkbox"/> Present Please specify <input type="checkbox"/> Criminal charge <input type="checkbox"/> Police warning <input type="checkbox"/> Other adult sanction	At any time PRIOR to the most recent sexual offense, the adolescent was cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time PRIOR to the most recent sexual offense, the adolescent was cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault.
<input type="checkbox"/> Not Present	Adolescent was NEVER cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault PRIOR to the most recent sexual offense.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews or collateral reports including official documentation such as police records.

8. Threats of, or use of, excessive violence/weapons during sexual offense.

Adolescents who have used excessive violence and/or weapons during the commission of their sexual assault(s) are more likely at greater risk to commit further sexual assaults. The use of violence/weapons may be indicative of sexual arousal to violence (see #1), may reflect attitudes supportive of sexual violence (see #3), or may be related to an antisocial interpersonal orientation (see #14). Authors of existing risk-prediction checklists/guidelines have commented that adolescents at higher risk to reoffend sexually are those who have used violence and/or weapons during their sexual assaults (Bremer, 1998; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986). To date, there has been very little research regarding this factor, and findings are mixed. In one study, Kahn and Chambers (1991) found that those adolescents who made verbal threats during the commission of their sexual assaults were more likely to have subsequent sexual assault convictions. On the other hand, Långström and Grann (2000) found that an adolescent's use of weapons or death threats during the sexual assault was related to subsequent convictions for nonsexual offenses: not sexual offenses.

Authors of the MnSOST, an actuarial risk-estimation tool for adult male sexual offenders, noted the importance of assessing the use of force when predicting risk of sexual reoffending for adults (Epperson et al., 1998). Similarly, authors of the SVR-20 stated that both (I) physical harm to the victim and (II) the use of weapons or death threats during the sexual assault should be considered as indicators of higher risk of sexual reoffending (Boer et al., 1997).

Coding

<input type="checkbox"/> Present	During the commission of any past sexual assault, the adolescent has ever: <ul style="list-style-type: none"> Used excessive physical restraint or aggression beyond that which would be necessary to gain victim "compliance", OR Used, or threatened to use, a weapon (regardless of whether a weapon was actually present), OR Used, or threatened to use, physical violence with the victim or with others important to the victim, such as family members
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever used excessive physical restraint or aggression; OR used, or threatened to use, a weapon; OR used, or threatened to use, physical violence against the victim or with others important to the victim, such as family members
<input type="checkbox"/> Not Present	Adolescent has NEVER used excessive physical restraint or aggression; NEVER used, or threatened to use, a weapon; NEVER used, or threatened to use, physical violence against the victim or with others important to the victim, such as family members
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Given that many adolescent offenders minimize the amount of force used during the commission of their sexual assaults (Emerick & Dutton, 1993), it is essential to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

9. Ever sexually assaulted a child.

Adolescents who have ever intentionally sexually assaulted a prepubescent child are more likely at risk of continued sexual assaults. The choice of child victims may reflect either deviant sexual interest in children (see #1) or attitudes supportive of sexual interactions with children (i.e., that "children are not harmed" by sexual interactions with teens; see #3).

In their list of risk factors, Ross & Loss (1991) suggested that offenders who choose young children are at higher risk to reoffend. The empirical data from retrospective studies with adolescent sexual offenders are mixed. Although some authors have not found evidence that having a child victim is related to risk (Hagan & Cho, 1996; Långström and Grann, 2000; Rasmussen, 1999; Smith & Monastersky, 1986; Worling & Curwen, 2000a), both Kahn and Chambers (1991) and Sipe, Jensen, and Everet (1998) stated that the presence of a child victim was related to the risk of further sexual assaults.

With respect to adult sexual recidivism, Epperson et al. (1998) noted—in their actuarial assessment scheme—that offenders who select children are at higher risk to reoffend sexually.

Coding

<input type="checkbox"/> Present	Adolescent has EVER intentionally sexually assaulted a child victim under 12 years of age and at least 4 years younger than the adolescent.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally sexually assaulted a child victim under 12 years of age and at least 4 years younger than the adolescent.
<input type="checkbox"/> Not Present	Adolescent has NEVER intentionally selected and sexually assaulted a child victim under 12 years and at least 4 years younger than the adolescent.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

The term "intentionally" is used here to differentiate between those offenders who consciously target a specific victim versus those who offend against a victim primarily because of the circumstances. For example, an offender who was exposing to a peer-age female may have also been seen by a young child. In this case, this factor would not be coded as present.

Although it is *generally* considered important to ensure that there is at least a 4-year age difference between the adolescent and their child victim, factors such as the differences in size and level of emotional maturity between the offender and the child are also important to consider.

It is essential to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

10. Ever sexually assaulted a stranger.

Adolescents who have ever intentionally sexually assaulted a stranger are most likely at greater risk of continued sexual offending. This may be partly attributable to the fact that lengthy grooming behaviours are unlikely and that offenses can occur quickly once a victim has been identified. Furthermore, the availability of strangers is certainly substantial relative to the number of individuals known to the offender.

In their risk-assessment guidelines, Ross & Loss (1991) suggested that adolescents who consistently target strangers are at a higher risk of a sexual reoffense. To date, the research support for this factor is consistent. Specifically, Smith and Monastersky (1986) found that the selection of stranger victims was significantly related to subsequent sexual reoffending, and Långström and Grann (2000) reported that adolescents who offended sexually against a stranger were almost 3 times more likely to be convicted of a subsequent sexual offense.

Results of retrospective research with adult male sexual offenders have indicated that the selection of victims who are strangers is related to sexual reoffending (Hanson & Bussière, 1998). Actuarial systems of risk prediction for adult male sexual offenders include the selection of stranger victims as an indicator of higher risk (Epperson et al., 1998; Hanson & Thornton, 1999).

Coding

<input type="checkbox"/> Present	Adolescent has EVER intentionally committed a sexual offense against a stranger. A victim is considered a stranger if she/he knew the adolescent for a period of less than 24 hours prior to the sexual offense.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally committed a sexual offense against a stranger.
<input type="checkbox"/> Not Present	Adolescent has NEVER committed a sexual offense against a stranger.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor is usually available from self-report, victim-impact statements, or collateral reports. Some offenders may claim that victims were known to them prior to the assault; however, contrary evidence that the victim was unknown should be considered as an indication that the offender was indeed a stranger to the victim.

It is essential to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

11. Indiscriminate choice of victims.

Adolescents who have committed sexual offenses against both males and females, or against individuals both within and outside of family relationships, or against known and stranger victims, or against victims of a variety of ages (i.e., children and peers/adults) are likely at a higher risk to reoffend. In part, the risk is likely greater because more individuals are possible targets of the offender's sexual aggression. Indiscriminate victim choice may reflect a more diverse pattern of deviant sexual interest (e.g., both children and forced sex with peers; see #1) and/or a more diverse pattern of attitudes supporting sexual offending (e.g., that "children are unharmed" and that peers "welcome" forced sexual contact; see #3).

Although there is currently no empirical support for this risk factor, this variable has never been studied in research with adolescents. In a recent discussion of risk prediction for adolescent sexual offenders, Epps (1997) noted that offenders who select both males and females or who offend against victims of a variety of ages are at greater risk to reoffend sexually.

With respect to adult sexual offenders, Hanson and Bussière (1998) found that there was a significant relationship between sexual recidivism and sexual assaults against both male and female children. On the SVR-20, Boer et al. (1997) noted that offenders who select a variety of victims (i.e., both males and females; both children and peers; both acquaintances and strangers) are at higher risk for sexual recidivism.

Coding

<input type="checkbox"/> Present	Adolescent has ever intentionally sexually assaulted: <ul style="list-style-type: none"> • <i>Both male and female victims</i> OR • <i>Both child (under 12 years of age and 4 years younger) and peer/adult victims</i> OR • <i>Both related and unrelated victims</i> OR • <i>Both familiar and stranger victims</i> (stranger if victim knew adolescent for less than 24 hours prior to sexual assault)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally sexually assaulted <i>both male and female victims</i> OR both child and peer/adult victims OR both related and unrelated victims OR both familiar and stranger victims .
<input type="checkbox"/> Not Present	Adolescent has NEVER intentionally sexually assaulted <i>both male and female victims</i> OR both child and peer/adult victims OR both related and unrelated victims OR both familiar and stranger victims .
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

"Related" victims would include individuals with a familial relationship to the offender such as full, step, half, adopted, and foster siblings, cousins, nieces, nephews, and parents. Of course, the length of the relationship will also be important to consider. For example, an offense against a child in a recent foster placement would likely not be coded as "familial".

A victim is considered a stranger if she/he knew the adolescent for a period of less than 24 hours prior to the sexual offense.

It is essential to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

12. Ever sexually assaulted a male victim (Coded for male offenders only).

Adolescent males who have intentionally selected and sexually assaulted a male victim are more likely at higher risk to reoffend sexually. Research with adolescent sexual offenders regarding this issue is mixed at this point. Both Smith and Monastersky (1986) and Långström and Grann (2000) found that adolescent males who selected male victims were more likely to have committed a subsequent sexual offense. Conversely, we (Worling & Curwen, 2000a) found that, for both male and female adolescent offenders, victim gender (i.e., same versus different) was unrelated to subsequent sexual offending. Rasmussen (1999) also found that the number of male victims was unrelated to sexual recidivism for a group of adolescent male offenders. Given the strength of this finding for adult male sexual offenders, however, and support from two studies with adolescents, this factor is included herein.

With respect to adult sexual offenders, men who have ever offended against male children are rated as higher risk when using the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) (Hanson, 1997), the Static-99 (Hanson & Thornton, 1999), and the SORAG (Quinsey et al., 1998). In their meta-analysis of retrospective studies of primarily adult males, Hanson and Bussière (1998) found that sexual recidivism was significantly related to the selection of male victims.

Coding

<input type="checkbox"/> Present	Male adolescent has EVER intentionally sexually assaulted a male victim.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the male adolescent has ever intentionally selected and sexually assaulted a male victim.
<input type="checkbox"/> Not Present	Male adolescent has NEVER intentionally selected and sexually assaulted a male victim.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

The term "intentionally" is used here to differentiate between those offenders who consciously target a specific victim versus those who offend against a victim primarily because of the circumstances. For example, a male offender who was purposely exposing himself to a female may have also been seen by male. In this case, this factor would not be coded as present.

It is essential to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

13. Diverse sexual-assault behaviours.

Adolescents who have committed a diverse array of sexual assaults are more likely at greater risk of further sexual aggression towards others. Diversity in sexual-assault behaviours may reflect increased risk because of escalation (e.g., noncontact and then contact offenses) or it may represent diversity in deviant sexual interests (see #1) and attitudes (see #3). Authors of existing risk-assessment checklists for adolescent sexual offenders have listed diversity of sexual offense behaviours as a high-risk indicator (Epps, 1997; Perry & Orchard, 1992). To date, this risk factor has not been examined in research with adolescents.

With respect to adult sexual offenders, Hanson and Harris (1998) found that those adult males with more paraphilias were more likely to have subsequent charges for a sexual assault, and the SVR-20 (Boer et al., 1997) includes the presence of multiple sex offense types as an indicator of greater risk.

Coding

<input type="checkbox"/> Present	Adolescent has EVER attempted or engaged in several different contact and/or non-contact sexual-assault behaviours including (but not limited to) exhibitionism, voyeurism, obscene phone calling, stalking, assault with a weapon, frottage, bestiality, sexual touching, or oral, anal, or vaginal penetration.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever attempted or engaged in several different contact and/or non-contact sexual-assault behaviours including (but not limited to) exhibitionism, voyeurism, obscene phone calling, stalking, assault with a weapon, frottage, bestiality, sexual touching, or oral, anal, or vaginal penetration.
<input type="checkbox"/> Not Present	Adolescent has engaged in one form of sexual assault behaviour ONLY.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Given that many offenders tend to minimize the extent and intrusiveness of their sexual assaults (Emerick & Dutton, 1993), it will be critical to examine all sources of information including clinical interviews, victim-impact statements, police reports, and other collateral data.

14. Antisocial interpersonal orientation.

Adolescent sexual offenders who display an antisocial interpersonal orientation are more likely to be at a higher risk of further sexual offenses. Of course, these adolescents are also more likely to be at a higher risk of nonsexual offenses as well. Adolescents who display an antisocial orientation are more concerned with meeting their own needs at the expense of the needs and feelings of others and in defiance of societal rules, conventions, and laws.

To date, the research regarding this factor is mixed. Although Hare (personal communication, September 24, 1999) stated that the total score from the Hare Psychopathy Checklist-Revised (Hare, 1991: PCL-R) significantly differentiated adolescent sexual offenders who reoffended sexually from those who did not, Långström and Grann (2000) found no significant relationship between PCL-R scores and adolescent sexual recidivism. In our (Worling & Curwen, 2000a) recent study, we did not find that antisocial personality features (as measured by the California Psychological Inventory) were predictive of sexual recidivism. It is important to note, however, that Långström and Grann (2000) and Worling and Curwen (2000a) found that antisocial personality was a significant predictor of nonsexual criminal recidivism. In available risk-prediction checklists/guidelines for adolescents, a history of antisocial behaviours and/or a delinquent orientation is a marker of higher risk for sexual recidivism (Bremer, 1998; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991).

The total score from the PCL-R is included as one of the variables in the SORAG to predict adult sexual recidivism (Quinsey et al., 1998). Hanson and Bussière (1998) also found that antisocial personality was significantly related to sexual recidivism in their meta-analysis of retrospective studies with primarily adult male sexual offenders. Finally, The SVR-20 includes Psychopathy as an indicator of greater risk for sexual recidivism for adults (Boer et al., 1997).

Coding

<input type="checkbox"/> Present	During the past 6 months, the adolescent has exhibited an antisocial interpersonal orientation as evidenced by the presence of 4 or more of the following: <ul style="list-style-type: none"> • Endorsement of antisocial or pro-criminal attitudes • Defiance of authority figures • Insensitive disrespect for the rights / feelings of others • Selfish / self-centered orientation • Difficulty accepting responsibility for most wrongdoings (not just sexual) • Lack of guilt or remorse for most wrongdoings (not just sexual) • Frequent lying and deception • Inflated sense of self-importance and self-worth • Emotionally unresponsive or emotions that appears "faked" • Frequent violations of rules and laws—in addition to sexual assaults(s)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has exhibited an antisocial interpersonal orientation (just 2 or 3 of the above) during the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT exhibited an antisocial interpersonal orientation during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Please note that if an offender fails to accept responsibility for his or her sexual assault *only*, or lack's remorse or guilt regarding sexual assault *only*, it does not necessarily mean that this factor is present. It is also essential to stress that the presence of this factor does **NOT** constitute a diagnosis of psychopathy or antisocial personality disorder. Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

15. Lack of intimate peer relationships / Social isolation.

Adolescent sexual offenders who are unable to form emotionally intimate peer relationships or who are socially isolated are likely at higher risk to commit further sexual offenses. Without intimate peer relationships, adolescents are likely to feel lonely and isolated, and they may turn to children and/or forced sex with peers/adults when they desire sexual interactions. Although there is no evidence for a link between broadly-defined "social" difficulties and sexual recidivism (Kahn & Chambers, 1991; Worling & Curwen, 2000a), it is likely that the more specific social deficit—inability to form and maintain an emotionally intimate relationship with a peer—is related to risk of further sexual assaults. With respect to social isolation, Långström and Grann (2000) found that those adolescent offenders with few extrafamilial peer relationships were at significantly higher risk of being convicted for a subsequent sexual offense. Social isolation is also listed as a high-risk indicator in previous checklists/guidelines regarding adolescent sexual offenders (Bremer, 1998; Lane, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991). Epps (1997) listed chronic peer/relationship difficulties as an indicator of increased risk for adolescents to reoffend sexually. In a recent meta-analysis of research with violent adolescents (including sexual offenders), Lipsey and Derzon (1998) noted that the most robust predictor of violent reoffending (including sexual) was peer unpopularity and lack of social activities.

Grubin (1999) suggested that a long-standing history of social isolation is an indicator of higher risk for adult sexual recidivism. In a recent publication of the Association for the Treatment of Sexual Abusers, Hanson (2000) suggested that intimacy deficits could be one of the more promising dynamic (potentially changeable) factors for predicting risk of sexual recidivism for adults. Similarly, the authors of the SVR-20 noted that offenders who display relationship problems are at higher risk of reoffending (Boer et al., 1997).

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent's social relationships have been characterized by: <ul style="list-style-type: none"> No emotionally intimate peer relationships (peers are non-familial individuals who are within 3 years of age from the adolescent), OR No close friendships OR reliance on a single peer-aged friend, OR Social isolation from peers outside of the regular school day.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has had no emotionally intimate peer relationships, relied on a single peer friendship, and/or was socially isolated from peers outside of the regular school day.
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent HAS had emotionally intimate peer relationships, or 2 or more close friends, and/or has not been socially isolated from peers outside of the regular school day.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

"Emotionally intimate" refers to "mutual self-disclosure in relationships, warmth and affection, and closeness and interdependence between partners" (Ward, McCormack, & Hudson, 1997).

Although information for this factor can be collected from the youth (i.e., clinical interviews, psychological testing), it is also important to collect information from other sources such as parents, peers, and the school. For example, it is often difficult for adolescents to acknowledge that they have no close friends.

16. Negative peer associations and influences.

Adolescent sexual offenders who associate with peers who often engage in antisocial or criminal activities are likely at higher risk to commit further sexual offenses. This is likely most pronounced in situations where the adolescent committed prior sexual assaults together with 1 or more peer offenders, or where the adolescent has previously attempted to gain social approval through sexual aggression.

Although there are few empirical data to support the inclusion of this factor at present, this may be a result of the fact that it has rarely been studied in research specifically with sexual offenders. On the other hand, in research with general juvenile delinquency (including sexual offenders), association with an antisocial peer group is one of the most robust predictors of subsequent criminal recidivism (e.g., Lipsey & Derzon, 1998; Loeber, 1990). Available risk-prediction checklists/guidelines for adolescents include antisocial peer group as an indicator of higher risk for sexual recidivism (Bremer, 1998; Prentky et al., 2000; Ross & Loss, 1991).

There has been very little research regarding the impact of peer associations on adult sexual assault recidivism; however, in a recent publication by the Association for the Treatment of Sexual Abusers, Hanson (2000) noted that this factor is a promising dynamic (potentially changeable) risk-prediction variable. In particular, Hanson (2000) stated that offenders at greater risk are those who associate with "peers who support either deviant lifestyles or inadequate coping strategies" (p. 3).

Coding

<input type="checkbox"/> Present	On more than 1 occasion within the past 6 months, the adolescent has associated with peers who: <ul style="list-style-type: none"> • Often engage in antisocial / criminal activity, OR • Often use non-prescription drugs and/or alcohol, OR • The adolescent frequently engaged in antisocial / criminal behaviours to "fit in" or "belong" with a peer group
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, on more than 1 occasion within the past 6 months, the adolescent has associated with peers who: <ul style="list-style-type: none"> • Often engage in antisocial / criminal activity, OR • Often use non-prescription drugs and/or alcohol, OR • The adolescent frequently engaged in antisocial / criminal behaviours to "fit in" or "belong" with a peer group
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT associated with peers who often engage in antisocial / criminal activity or substance use / abuse behaviours on more than 1 occasion.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

17. Interpersonal aggression.

Adolescent sexual offenders who have demonstrated a pattern of interpersonal aggression—in addition to their sexual offense(s)—are most likely at higher risk of committing further sexual offenses. Adolescents who are aggressive and hurtful towards others may demonstrate an antisocial interpersonal orientation (see #14), or they may have learned to cope with personal difficulties by relying on aggressive behaviours.

Available risk-prediction checklists for adolescent sexual offenders suggest that a history of interpersonal aggression is an indicator of risk for continued sexual offending (Bremer, 1998; Epps, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Wenet & Clark, 1986). Interpersonal aggression has also been found to be a good predictor of general (including sexual) juvenile reoffending (e.g., Lipsey & Derzon, 1998; Loeber, 1990).

Coding

<input type="checkbox"/> Present	During the past 6 months, the adolescent has demonstrated a pattern of interpersonal aggression, characterized by a number of verbally or physically abusive behaviours directed towards people
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has demonstrated a pattern of interpersonal aggression, characterized by a number of verbally or physically abusive behaviours directed towards people.
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT demonstrated a pattern of interpersonal aggression characterized by a number of verbally or physically abusive behaviours directed towards people.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

18. Recent escalation in anger or negative affect.

Adolescent sexual offenders who demonstrate a recent escalation in either anger or negative affect are more likely to present a higher risk of continued sexual aggression. Negative affect such as sadness, anger, boredom, loneliness, frustration, and feelings of worthlessness, abandonment, and rejection have been cited as immediate precursors to adolescent sexual offenses (e.g., Gray & Pithers, 1993; Richardson & Graham, 1997; Steen & Monnette, 1989; Way & Spieker, 1997). There is currently no empirical support for this factor with respect to the prediction of sexual recidivism for adolescents; however, this may be the result of the fact that it has never been investigated.

With respect to existing risk-prediction checklists/guidelines for adolescents, Bremer (1998) suggested that adolescent sexual offenders who display flat affect or a notable emotional disturbance are at a higher risk to reoffend.

It is important to note that this factor is specifically related to the youth's recent escalation in anger or negative affect—not the mere presence or absence of anger or negative affect. For example, there appears to be little relationship between the **level** of anger or depression at the time of initial assessment and later sexual recidivism (Worling & Curwen, 2000a).

With respect to research with adult sexual offenders, Hanson and Harris (2000) have included a worsening of negative mood (e.g., loneliness, anxiety, depression) on the SONAR as a high-risk marker for reoffending. Furthermore, Proulx, McKibben, and Lusignan (1996) found that anger or negative affect (e.g., loneliness, humiliation) preceded masturbation to deviant fantasies for a group of adult male sexual offenders.

Coding

<input type="checkbox"/> Present (please note) <input type="checkbox"/> Anger <input type="checkbox"/> Negative affect	At any time within the past 6 months, the adolescent has demonstrated an escalation in: <ul style="list-style-type: none"> • Anger (e.g., tantrums, verbal or physical aggression, threats), OR • Negative affect such as depression, anxiety, loneliness, boredom, or frustration <p>NOTE: this factor represents ONLY an escalation, or heightening, of anger or negative affect—NOT merely the presence of anger or negative affect</p>
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has demonstrated an escalation in: <ul style="list-style-type: none"> • Anger (e.g., tantrums, verbal or physical aggression, threats), OR • Negative affect such as depression, anxiety, loneliness, boredom, or frustration
<input type="checkbox"/> Not Present	NO escalation in anger or negative affect during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews, observation, psychological test results, or collateral reports.

19. Poor self-regulation of affect and behaviour (Impulsivity).

Adolescent sexual offenders who are highly impulsive, and who have difficulty regulating their behaviours and their affective expression are likely at greater risk of continued sexual offending. Conversely, adolescents who more carefully consider the consequences of their behaviours before acting are likely at lower risk. Although there is no empirical support for this factor with respect to the prediction of sexual recidivism for adolescents, this may be the result of the fact that it has never been investigated. On the other hand, there is considerable support in research with general juvenile delinquency (including sexual offenders) for the inclusion of impulsivity as an indicator of greater risk for criminal recidivism (e.g., Lipsey & Derzon, 1998; Loeber, 1990).

Bremer (1998), Epps (1997), Lane (1997), and Prentky et al. (2000) have noted that adolescent sexual offenders who are generally impulsive are at greater risk to reoffend sexually. With respect to adult sexual offenders, Hanson (2000) suggested that general self-regulation is one of the more promising dynamic factors for predicting risk of sexual recidivism for adults, and Hanson and Harris (2000) have included general self-regulation as a high-risk marker on the SONAR: an actuarial tool for predicting adult sexual recidivism.

Coding

<input type="checkbox"/> Present	During the past 6 months, the adolescent has demonstrated very poor self-regulation of affect and behaviour. Impulsivity is demonstrated by 3 or more of the following: <ul style="list-style-type: none"> • Frequent difficulty delaying gratification • Frequent difficulty delaying responses ("blurring out answers") • Frequently interrupting others • Frequent failure to listen to instructions or directions • Frequently becoming bored with routine • Frequently grabbing or touching things/others without permission • Frequent failure to consider consequences before engaging in activities (particularly potentially dangerous or risky activities)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has demonstrated very poor self-regulation of affect and behaviour—is typically highly impulsive (2 or fewer of the above).
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT demonstrated very poor self-regulation of affect and behaviour—is typically NOT impulsive.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information regarding self-regulation is typically readily available from clinical interviews, collateral reports (e.g., school, parents), and from psychological testing.

20. High-stress family environment.

An adolescent sexual offender who is a member of a family that is currently characterized by an elevated level of distress is likely at an increased risk of reoffending sexually. High levels of family distress will undoubtedly impact on the adolescent in a variety of ways—depending on the particular source of stress. For example, heightened marital discord may contribute to feelings of insecurity for the adolescent. Alternatively, violent family relationships could serve to contribute to increased feelings of low self-worth, depression, and rejection. A high-stress family environment may serve to heighten the adolescent's negative emotional states such as anger, abandonment, depression, or loneliness; thus increasing the likelihood that the adolescent will choose to reoffend. Furthermore, a high-stress family environment may keep the focus of professional interventions solely on family issues at the expense of the offender's other high-risk factors. If the adolescent is currently living with his/her family, it is also likely that a high level of family stress will be related to an environment in which adults are less vigilant regarding the offender's high-risk factors (see #23).

In their recent meta-analysis of recidivism research regarding violent (including sexual) juvenile offenders, Lipsey and Derzon (1998) found that a high level of family distress was a significant predictor of subsequent criminal reoffending.

There have not yet been empirical studies of the relation between this factor and adolescent sexual reoffending. Available risk-prediction checklists/guidelines for adolescent sexual offenders include extreme family dysfunction or distress as an indicator of high risk for sexual reoffending (Bremer, 1998; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986). Prentky et al. (2000) suggested that multiple changes in caregivers was indicative of greater risk of recidivism.

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, REGARDLESS of where the adolescent has been living, there has been an extreme level of stress within the family as evidenced by issues such as: <ul style="list-style-type: none"> • Marked marital discord • Death of a family member • Separation of a family member from family • Major illness of a family member • Significant family change in residence, employment, or income • Poverty • Criminal activity of family member other than adolescent • Sexual or physical victimization within the family (not including the adolescent's index sexual offense) • Highly conflictual family relationship(s) (OTHER THAN offender-parent relationship)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent's family has experienced high levels of stress at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent's family has NOT experienced high levels of stress during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

It is essential to evaluate the family's **reaction** (i.e., level of distress) to the potential stressor **rather than** simply the mere presence of a factor that would be stressful for others. For example, some families will not evidence high levels of distress if there is a change in residence. Information regarding this factor can be obtained through observation, interviews with the offender and the family, collateral reports, and psychological testing.

21. Problematic parent-offender relationships / Parental rejection.

Adolescent sexual offenders who currently have highly problematic relationships with a parent, and/or who feel rejected by a parent are likely at greater risk of further sexual assaults. As in the case of high-stress family environments (see #20), a problematic parent-child relationship and/or parental rejection is likely to contribute to increased anger or negative affect such as depression, hopelessness, rejection, and abandonment; feelings that could heighten the risk for the adolescent to choose to reoffend.

Presently, empirical support for the inclusion of this factor for adolescent sexual offenders is limited to one study. We (Worling & Curwen, 2000a) recently found a moderate correlation between the offenders' feelings of parental rejection and subsequent sexual recidivism. In their meta-analysis of recidivism research, Lipsey and Derzon (1998) found that poor parent-child relations (characterized by such attributes as low warmth, low parental involvement, punitive discipline, and negative attitude toward the child) were significantly related to subsequent violent (including sexual) reoffending. Loeber (1990) also pointed out that parent-child difficulties marked by poor discipline or parental rejection are strong predictors of later antisocial behaviours for adolescents.

In their discussion of risk prediction for adolescent sexual offenders, Ross & Loss (1991) suggested that offender-parent relationships that are marked by role reversal, emotional unavailability, and abuse are indicators of higher risk to reoffend sexually. Similarly, Lane (1997) suggested that adolescents who have a close relationship with a parent are at a lower risk for sexual reoffending.

In their meta-analysis of retrospective studies of primarily adult males, Hanson and Bussière (1998) found that men who, when they were young, had a negative relationship with their mother were more likely to have subsequent sexual assaults.

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has experienced an extremely problematic parent-child relationship as evidenced by: <ul style="list-style-type: none"> • Adolescent feeling rejected, unloved, or unwanted by a parent(s) • Parent's current use of harsh/punitive verbal or physical discipline • Very low level of parental involvement; particularly if the parent was once more involved in the adolescent's life • Significant parent-child conflict / disagreement
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has experienced an extremely problematic parent-child relationship or has felt rejected, unloved, or unwanted by a parent(s).
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT experienced an extremely problematic parent-child relationship or has NOT felt rejected, unloved, or unwanted by a parent(s).
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

For this factor, the parental relationship(s) with the offender should be coded (i.e., NOT the parental relationship with the offender's siblings).

Information for this factor would be available from clinical interviews with the adolescent and family members, collateral reports, and psychological testing.

22. Parent(s) not supporting sexual-offense-specific assessment/treatment.

Adolescent sexual offenders whose parent(s) is unsupportive of sexual-offense-specific assessment/treatment are likely to be at a greater risk of reoffending sexually. Making changes in many of the dynamic (or potentially changeable) risk factors listed herein requires considerable effort and commitment on the part of the adolescent. Given the significance of parent-child relationships during adolescence, the support of a parent(s) is important for adolescents to make the changes necessary to manage their risk of reoffending. Furthermore, as noted in #20 and #21 above, parent-child conflict or family-stress issues can be related to the risk of reoffense, and parental involvement and support regarding treatment is essential in managing risk. Parents not supportive of offense-specific treatment may also foster an environment that is supportive of reoffending (see #23).

Two recent investigations have demonstrated the importance of working with families, wherever possible, to assist adolescents to reduce their risk of both sexual and nonsexual reoffending (Borduin, Henggeler, Blaske, & Stein, 1990; Worling & Curwen, 2000a). Authors of existing risk-prediction checklists/guidelines for adolescent sexual offenders have noted that offenders are at greater risk when their parents are not supportive of sexual-offense-specific treatment (Calder et al., 1997; Epps, 1997; Lane, 1997; Perry & Orchard, 1992; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986).

Coding

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent's parent(s) has not been supportive of sexual-offense-specific assessment/treatment for their child as evidenced by one or more of the following: <ul style="list-style-type: none"> • Parental refusal to participate in assessment/treatment • Parental refusal to allow child to participate in assessment/treatment • Parent(s) denies that their child committed the sexual assault despite evidence to the contrary • Parent(s) denies that there is ANY risk of sexual reoffense • Parent(s) attempts to undermine or minimize the adolescent's sexual-offense-specific assessment/treatment
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent's parent(s) has not been supportive of sexual-offense-specific assessment/treatment for their child.
<input type="checkbox"/> Not Present	Adolescent's parent(s) HAS been supportive of sexual-offense-specific assessment/treatment for their child during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

Information for this factor may be obtained through clinical interviews with the adolescent and parent(s), observation, or collateral reports.

23. Environment supporting opportunities to reoffend sexually.

Adolescent sexual offenders who spend considerable periods of time in environments supporting opportunities to reoffend sexually are likely at higher risk to commit subsequent sexual offenses. For example, adolescent offenders who are provided with unsupervised access to potential victims, who often "test" themselves by purposely entering high-risk environments, or who reside with adults who deny the presence of high-risk indicators are more likely to commit further sexual offenses.

Despite the intuitive logic of this argument, there is surprisingly little research available at present with either adolescent or adult sexual offenders to support the inclusion of this factor. In a recent investigation of adult male sexual offenders, however, Hanson and Harris (1998) found that sexual recidivists were significantly more likely to place themselves in situations providing greater access to victims, and this factor was included in the SONAR (Hanson & Harris, 2000).

Epps (1997) and Ross and Loss (1991) suggested that adolescent offenders who are provided unsupervised access to potential victims are at a greater risk to reoffend sexually. Prentky et al. (2000) suggested that a highly unstable environment characterized by such factors as abuse, substance use, poor boundaries, and pornography is likely related to higher risk of recidivism.

Coding

<input type="checkbox"/> Present	At the present time—or at any time within the NEXT 6 months—the adolescent is residing in, or often visiting, an environment that supports opportunities to reoffend sexually as evidenced by one or more of the following: <ul style="list-style-type: none"> • Unsupervised access to potential and/or past victims • Poor monitoring or control of adolescent's whereabouts • Adult denial of adolescent's risk to reoffend sexually • Lack of adult awareness of adolescent's high-risk factor(s) • Easy access to sexual media (pictorial, auditory, or textual) • Exposure to frequent sexual behaviours, gestures, or conversations • Supervising adults who blame the victim(s) for the adolescent's offense(s)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at the present time—or at any time within the NEXT 6 months—the adolescent is residing in, or often visiting, an environment that supports opportunities to reoffend sexually.
<input type="checkbox"/> Not Present	BOTH presently AND during the NEXT 6 months, the adolescent will NOT be residing in, or often visiting, an environment that supports opportunities to reoffend sexually.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

It is important to consider environments such as the offender's place of residence, school, homes of peers and relatives, or any other place(s) that the adolescent visits with some regularity.

Information for this factor may be obtained through clinical interviews with the adolescent, interviews with those familiar with the environment(s) in question, direct observation, or collateral reports.

24. No development or practice of realistic prevention plans/strategies.

Adolescent sexual offenders who do not demonstrate some practice of realistic prevention plans or strategies are more likely at higher risk of committing further sexual assaults. Although it is difficult to ascertain whether or not an adolescent is truly using skills taught during treatment, the offender can at least report that she or he has acquired and can utilize realistic offense-prevention plans. There is currently no empirical support for the inclusion of this factor; however, although this may be due to the fact that it has never been studied.

In their risk-prediction checklist, Perry and Orchard (1992) noted that offenders who have little awareness of offense-prevention strategies are at heightened risk to reoffend sexually. Similarly, Prentky et al. (2000) suggested that offenders who demonstrate a poor understanding of their offense chain and, therefore, are unable to identify triggers or high-risk markers are at higher risk of reoffending sexually.

Coding

<input type="checkbox"/> Present	<p>During the past 6 months:</p> <ul style="list-style-type: none"> The adolescent has not developed a realistic plan to cope with potentially high-risk factors for a sexual reoffense (such as deviant sexual arousal), OR The adolescent has not practiced realistic strategies to cope with potentially high-risk factors. <p>NOTE: "realistic" plans/strategies are those that would be considered sensible, practical, and socially acceptable.</p>
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has not developed or practiced realistic strategies to cope with potentially high-risk factors for a sexual reoffense (such as deviant sexual arousal).
<input type="checkbox"/> Not Present	Adolescent HAS BOTH developed AND practiced at least some realistic plan(s) to cope with high-risk factors for a sexual reoffense during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

"Realistic" offense-prevention plans/strategies are those deemed likely, sensible, socially acceptable, and practical given the offender's circumstances. It would not be considered "realistic", for example, if an offender avoided sexual assaults by physically pushing away potential victims. Similarly, it would not be "realistic" for an offender to stay in his/her room all day to reduce the risk of reoffending.

Information for this factor may be obtained through clinical interviews with the adolescent, observation, psychological testing, or collateral reports.

25. Incomplete sexual-offense-specific treatment.

Adolescent sexual offenders who have yet to complete sexual-offense-specific treatment are likely at higher risk to reoffend sexually than are those offenders who have completed treatment. Adolescents who have completed treatment are likely better able to cope with many of the other dynamic (or changeable) high-risk factors outlined herein. Recent research has demonstrated that those adolescent sexual offenders who participated in comprehensive treatment that combined a strong family-relationship component along with sexual-offense-specific interventions were less likely to commit further sexual and nonsexual offenses (Borduin et al., 1990; Worling & Curwen, 2000a). In available risk-prediction checklists/guidelines regarding adolescent sexual recidivism, Epps (1997), Lane (1997), Perry and Orchard (1992), Ross and Loss (1991), and Steen and Monnette (1989) noted that those adolescents who are most unwilling to engage in offense-specific treatment are at higher risk to reoffend.

With respect to adults, there is certainly much debate regarding treatment efficacy (e.g., Harris et al., 1998; Marques, 1999). It should be pointed out, however, that in their recent meta-analysis, Hanson and Bussière (1998) found that those adult males who completed sexual offender treatment were significantly less likely to reoffend sexually. Boer et al. (1997) also stated that those offenders who display a negative orientation toward treatment are at higher risk of reoffending sexually.

Coding

<input type="checkbox"/> Present	Adolescent has not yet completed a majority (i.e., 75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has not yet completed a majority (i.e., 75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Not Present	Adolescent HAS completed a majority (75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

If the adolescent "drops out" of treatment after a substantial period of successful involvement in sexual-offense-specific treatment (e.g., 2 years), one may want to consider that this factor is not present even though several treatment goals were not completed.

"Offense-specific-treatment" refers to treatment for adolescent sexual offenders that specifically addresses issues related to risk of sexual recidivism such as deviant sexual arousal, attitudes supportive of sexual offending, knowledge of victim impact, and other factors listed above as they relate to the individual's sexual offense risk such as family distress, parent-child relationships, and affective expression. Of course, in addition to evaluating the adolescent with respect to this factor, it will be important to collect information from the therapist(s) who has provided sexual-offense-specific treatment.

Commonly Cited Risk Factors Not *Currently* Supported in Research

The factors addressed in this section should be used with extreme caution (if at all) when formulating risk estimates for adolescents—at least at the present time—given the lack of empirical support. Perhaps with the collection of additional data in the future, and/or better measurement techniques, these factors will be demonstrated to be related to subsequent risk.

Denial of the sexual offense

It is almost an article of faith that offenders who deny their sexual crimes are at higher risk to reoffend sexually. Adolescents who deny that they were present at the time of the assault, who deny that the interaction was at all sexual, or who deny that the sexual interaction was assaultive (i.e., maintain it was consensual between peers) are often judged to be high risk until they can begin to acknowledge their offenses in some capacity. Indeed, all of the available risk prediction checklists/guidelines list denial of the sexual offense as a high risk marker (Bremer, 1998; Epps, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986). The available research indicates that, on the contrary, adolescent sexual offenders who deny their sexual crimes are not more likely to reoffend sexually (Kahn & Chambers, 1991; Långström and Grann 2000). Further analysis of the available file data from our recent study (Worling & Curwen, 2000a) revealed that those adolescents who denied their sexual assaults were significantly less likely to reoffend sexually (Worling, in press). In their recent meta-analysis of studies of adult sexual offenders, Hanson and Bussière (1998) found that there was no relation between denial of the index sexual offense and subsequent sexual recidivism.

Lack of victim empathy

As in the case of denial, almost all published checklists/guidelines include the lack of remorse or empathy as evidence of heightened risk for adolescent sexual offenders (Epps, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Steen & Monnette, 1989; Wenet & Clark, 1986). It is widely assumed that offenders who are unable to appreciate the harm that they have caused, or who have difficulty demonstrating empathy for their victims, are likely to repeat their sexual assaults. Despite the strength of this clinical assumption, however, there are currently no data supporting the use of this factor to predict sexual recidivism. For example, Smith and Monastersky (1986) found that there was no significant relation between sexual recidivism after a mean of 28 months and the offender's inability to understand the exploitiveness of their sexual offense(s). Similarly, Långström and Grann (2000) found that offenders with low general empathy were no more at risk of being reconvicted for a sexual crime. In their review of research with adults, Hanson and Bussière (1998) found that there was no relation between sexual recidivism and low empathy for victims. Perhaps if researchers devise different measures of victim empathy or remorse, support for the use of this variable will be found.

History of nonsexual crimes

A history of nonsexual crimes is noted as a risk factor for adolescent sexual recidivism in several published checklists/guidelines (Bremer, 1998; Epps, 1997; Perry & Orchard, 1992; Prentky et al., 2000; Ross & Loss, 1991; Wenet & Clark, 1986). Although it is certainly true that

a history of nonsexual criminal charges is related to sexual recidivism for adult male sexual offenders (Hanson & Bussière, 1998), there is a consensus in research completed to date that this factor is NOT related to subsequent sexual offenses for adolescent sexual offenders (Kahn & Chambers, 1991; Lab et al., 1993; Långström and Grann, 2000; Sipe et al., 1998; Rasmussen, 1999; Worling & Curwen, 2000a). As expected, however, most researchers have found that a history of nonsexual offenses is predictive of subsequent nonsexual crimes.

Offender's own history of child sexual abuse

It is assumed by some authors that those adolescents who are victims of child sexual abuse are at greater risk for reoffending sexually (Perry & Orchard, 1992; Steen & Monnette, 1989; Wenet & Clark, 1986). However, the available data indicate that adolescent sexual offenders who acknowledge a history of child sexual abuse are at no greater risk of sexual recidivism (Hagan & Cho, 1996; Rasmussen, 1999; Worling & Curwen, 2000a). With respect to adult sexual offenders, Hanson and Bussière (1998) also found that there was no relation between sexual offense recidivism and an offender's childhood sexual victimization history.

Penetrative sexual assaults

Authors of available checklists and guidelines suggest that adolescents who engage in penetrative (anal, vaginal, or oral) sexual assaults are at higher risk for reoffending sexually (Epps, 1997; Ross & Loss, 1991; Steen & Monnette, 1989). In the only study of this factor with adolescents, however, Långström and Grann (2000) found that victim penetration was unrelated to subsequent convictions for sexual offenses. Indeed, the data reported by these authors suggest that offenders who engaged in noncontact offenses are, on average, 3 times more likely to be reconvicted for a sexual offense. A history of noncontact offenses is counted as a high-risk factor for adult sexual offenders on the Static-99 (Hanson & Thornton, 1999). Furthermore, in their recent meta-analysis of retrospective studies of adult male sexual offenders, Hanson and Bussière (1998) found that the degree of sexual contact was unrelated to subsequent sexual assault recidivism.

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Table 1: Published Studies of Adolescent Sexual Offense Recidivism

Study	Country	Number and Gender of Participants	Age of Participants (in Years)	Length of Follow-up	Sexual Assault Recidivism Measure
Borduin, Henggeler, Blaske, & Stein, 1990	United States	16 males	<i>M</i> =14	<i>M</i> =3 years	Charges
Hagan & Cho, 1996	United States	100 males	12-19	2-5 years	Convictions
Kahn & Chambers, 1991	United States	221 ratio of males to females 20:1	8-18 <i>M</i> =14.7	<i>M</i> =20 months	Convictions
Lab, Shields, & Schondel, 1993	United States	151 males 1 female	<i>M</i> =14	1-3 years	Convictions
Långström & Grann, 2000	Sweden	44 males 2 females	15-20 <i>M</i> =18.13	<i>M</i> =60.95 months	Convictions
Rasmussen, 1999	United States	167 males 3 females	7-18 <i>M</i> =14	5 years	Convictions
Schram, Malloy, & Rowe, 1992	United States	197 males	<i>M</i> =14.5	5 years	Charges
Sipe, Jensen, & Everett, 1998	United States	124 males	11-18	<i>M</i> =6 years	Adult Charges
Smith & Monastersky, 1986	United States	112 males	10-16 <i>M</i> =14.1	<i>M</i> =28 months	Charges
Worling & Curwen, 2000a	Canada	139 males 9 females	12-19 <i>M</i> =15.5	2-10 years <i>M</i> =6.23 years	Charges

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Feedback/Comments

We would appreciate hearing from evaluators who have used this document when completing sexual assault recidivism risk predictions with adolescents. We would also appreciate receiving any follow-up data that you have collected using this instrument. We are currently collecting data regarding the reliability (e.g., agreement between evaluators) and predictive validity of The *ERASOR*, and we will revise this document pending (1) new follow-up research with adolescents who have committed sexual assaults, (2) evaluators' comments and suggestions regarding the coding form, and (3) research regarding the reliability and validity of the instrument.

Please direct your comments and feedback to:

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Estimate of Risk of Adolescent Sexual Offense Recidivism (The "ERASOR"): Version 2.0

James R. Worling, Ph.D., & Tracey Curwen, M.A.
Sexual Abuse: Family Education & Treatment (SAFE-T) Program



Name of adolescent _____ Age _____ Coding Form Page 1

Name of evaluator _____ Date Completed _____

Date of Previous Risk Assessment _____ or ☐ n/a ID Number _____

The guidelines contained in The *ERASOR* were developed by the authors in the course of their duties at the SAFE-T Program. Anyone choosing to use or adopt the risk assessment guidelines outlined herein does so on the sole basis of their responsibility to judge their suitability for their own specific purposes. The Ontario Ministry of Community & Social Services, its employees, agents, servants and the authors neither assume nor accept any responsibility or legal liability for any injury or damages whatsoever resulting from the use of The *ERASOR* and the guidelines outlined herein.

The Estimate of Risk of Adolescent Sexual Offense Recidivism (The *ERASOR*) is an empirically-guided approach to estimating the risk of a sexual reoffense **for an adolescent, presently aged 12 to 18 years, who has previously committed a sexual assault**. When using The *ERASOR*, it is essential to be familiar with the content of the *ERASOR* manual included with this coding form. It is also important to stress that evaluators should:

- Have expertise and training regarding the assessment of adolescents and their families and expertise and training regarding the assessment and management of sexual aggression.
- Assess multiple domains of functioning including sexual, intrapersonal, interpersonal, familial, and biological.
- Use multiple methods of data collection to form opinions including clinical interviews, psychological tests, behavioural observation, and reviews of previous case records and reports.
- Collect information from multiple sources such as the offender, the victim(s), the police, family, friends, and other professionals who are familiar with the offender and his/her family.
- Be cognizant of the validity of the information that they are using in forming risk predictions.
- Be familiar with the research related to the estimation of adolescent sexual recidivism.
- Recognize that risk assessments will become obsolete after the passage of time and/or following a change in any of the risk factors that were assessed.

Given that there is currently no empirical support for a specific algorithm for combining risk factors to predict adolescent sexual recidivism, judgement is necessary to determine the level of risk (i.e., "low", "moderate", or "high"). It is anticipated that there will be a general relationship between the number of high-risk factors and the rating of risk such that more high-risk indicators suggest higher risk. However, the final decision will be more dependent on the combination of risk factors rather than just the number. Furthermore, it is possible that the presence of a single risk factor—such as the adolescent's stated intentions to reoffend—could be indicative of high risk.

1. Deviant sexual interests (younger children, violence, or both).

<input type="checkbox"/> Present <input type="checkbox"/> Children <input type="checkbox"/> Violence	<ul style="list-style-type: none"> At any time within the past 6 months, the adolescent has reported or demonstrated sexual arousal to thoughts/images of children under 12 years of age (and children who are at least 4 years younger than the adolescent), OR Sexual assaults—within the past year—against 2 or more children under 12 years of age (and children who are at least 4 years younger than the adolescent), OR At any time within the past 6 months, the adolescent has reported or demonstrated sexual arousal to sexual violence (excessive physical violence, threats of death or physical pain, use of weapons), OR Sexual assaults—within the past year—against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Possibly or Partially Present <input type="checkbox"/> Children <input type="checkbox"/> Violence	Possible or partial evidence that the adolescent <ul style="list-style-type: none"> has reported or demonstrated deviant sexual arousal to prepubescent children, sexual violence, or both, at any time within the past 6 months, OR Within the past year, has committed sexual assaults against 2 or more prepubescent children or sexual assaults against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Not Present	<ul style="list-style-type: none"> Adolescent has reported AND demonstrated NO sexual arousal to thoughts and/or images of prepubescent children, sexual violence, or both during the past 6 months, OR Within the past year, the adolescent has NOT committed sexual assaults against 2 or more children, or sexual assaults against 2 or more individuals that involved excessive physical violence, threats of death or pain, or use of weapons.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

2. Obsessive sexual interests/Preoccupation with sexual thoughts.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has demonstrated obsessive sexual interests/preoccupation with sexual thoughts as evidenced by any of the following: <ul style="list-style-type: none"> Unusually frequent masturbation Unusually frequent sexual thoughts, comments, gestures, or behaviours Unusually frequent use of pornography (or other textual, pictorial, or auditory materials considered erotic by adolescent) Unusually frequent engagement in sexual fantasy Excessive use of sexual behaviours/fantasies to cope with negative affect (boredom, loneliness, frustration, sadness), anger, or problematic situations.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has been preoccupied with sexual thoughts, behaviours, fantasies, images, or gestures at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT demonstrated obsessive sexual interests or preoccupation with sexual thoughts, behaviours, fantasies, images, or gestures during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

3. Attitudes supportive of sexual offending.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has endorsed ANY of the following attitudes: <ul style="list-style-type: none"> Sexual interactions with children under 12 years of age are not harmful to the child; are desired by the child; are often initiated by children; should be legalized; are just displays of affection; or are educational for the child, OR Forced sexual interactions with peers or adults are not harmful; are desired; are enjoyable; are initiated by the victim's style of dress or behaviour; or that disclosures of forced sexual interactions are usually fabricated.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has endorsed attitudes supportive of sexual offending at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT endorsed attitudes supportive of sexual offending during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

4. Unwillingness to alter deviant sexual interests/attitudes.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has been unwilling to alter or "give up" the: <ul style="list-style-type: none"> Deviant sexual interests that were rated as "Present" or "Possibly or Partially Present" in #1 above OR Attitudes supportive of sexual offending that were rated as "Present" or "Possibly or Partially Present" in #3 above
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has been unwilling to alter the: <ul style="list-style-type: none"> Deviant sexual interests that were rated as "Present" or "Possibly or Partially Present" in #1 above OR Attitudes supportive of sexual offending that were rated as "Present" or "Possibly or Partially Present" in #3 above
<input type="checkbox"/> Not Present	<ul style="list-style-type: none"> During the past 6 months, the adolescent HAS been willing to alter deviant sexual interests (#1 above) or attitudes supportive of sexual offending (#3 above), OR Neither #1 nor #3 above were coded as "Present" or "Possibly or Partially Present"
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

5. Ever sexually assaulted 2 or more victims.

<input type="checkbox"/> Present	Adolescent has intentionally sexually assaulted 2 or more victims.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has intentionally sexually assaulted 2 or more victims.
<input type="checkbox"/> Not Present	Adolescent has intentionally sexually assaulted 1 victim.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

6. Ever sexually assaulted same victim 2 or more times.

<input type="checkbox"/> Present	Adolescent has sexually assaulted the same victim on 2 or more occasions.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has sexually assaulted the same victim on 2 or more occasions.
<input type="checkbox"/> Not Present	Adolescent has NEVER sexually assaulted the same victim on more than 1 occasion.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

7. Prior adult sanctions for sexual assault(s).

<input type="checkbox"/> Present Please specify <input type="checkbox"/> Criminal charge <input type="checkbox"/> Police warning <input type="checkbox"/> Other adult sanction	At any time PRIOR to the most recent sexual offense, the adolescent was cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time PRIOR to the most recent sexual offense, the adolescent was cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault.
<input type="checkbox"/> Not Present	Adolescent was NEVER cautioned, warned, disciplined, criminally charged, or otherwise sanctioned by an adult authority (e.g., police, parent, teacher) for a sexual assault PRIOR to the most recent sexual offense.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

8. Threats of, or use of, excessive violence/weapons during sexual offense.

<input type="checkbox"/> Present	During the commission of any past sexual assault, the adolescent has ever: <ul style="list-style-type: none"> • Used excessive physical restraint or aggression beyond that which would be necessary to gain victim "compliance", OR • Used, or threatened to use, a weapon (regardless of whether a weapon was actually present), OR • Used, or threatened to use, physical violence with the victim or with others important to the victim, such as family members
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever used excessive physical restraint or aggression; OR used, or threatened to use, a weapon; OR used, or threatened to use, physical violence against the victim or with others important to the victim, such as family members
<input type="checkbox"/> Not Present	Adolescent has NEVER used excessive physical restraint or aggression; NEVER used, or threatened to use, a weapon; NEVER used, or threatened to use, physical violence against the victim or with others important to the victim, such as family members
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

9. Ever sexually assaulted a child.

<input type="checkbox"/> Present	Adolescent has EVER intentionally sexually assaulted a child victim under 12 years of age and at least 4 years younger than the adolescent.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally sexually assaulted a child victim under 12 years of age and at least 4 years younger than the adolescent.
<input type="checkbox"/> Not Present	Adolescent has NEVER intentionally selected and sexually assaulted a child victim under 12 years and at least 4 years younger than the adolescent.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

10. Ever sexually assaulted a stranger.

<input type="checkbox"/> Present	Adolescent has EVER intentionally committed a sexual offense against a stranger. A victim is considered a stranger if she/he knew the adolescent for a period of less than 24 hours prior to the sexual offense.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally committed a sexual offense against a stranger.
<input type="checkbox"/> Not Present	Adolescent has NEVER committed a sexual offense against a stranger.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

11. Indiscriminate choice of victims.

<input type="checkbox"/> Present	Adolescent has ever intentionally sexually assaulted: <ul style="list-style-type: none"> • <i>Both male and female victims</i> OR • <i>Both child (under 12 years of age and 4 years younger) and peer/adult victims</i> OR • <i>Both related and unrelated victims</i> OR • <i>Both familiar and stranger victims</i> (stranger if victim knew the adolescent for less than 24 hours prior to sexual assault)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever intentionally sexually assaulted <i>both male and female victims</i> OR <i>both child and peer/adult victims</i> OR <i>both related and unrelated victims</i> OR <i>both familiar and stranger victims</i> .
<input type="checkbox"/> Not Present	Adolescent has NEVER intentionally sexually assaulted <i>both male and female victims</i> OR <i>both child and peer/adult victims</i> OR <i>both related and unrelated victims</i> OR <i>both familiar and stranger victims</i> .
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

12. Ever sexually assaulted a male victim (*Coded for male adolescents only*).

<input type="checkbox"/> Present	Male adolescent has EVER intentionally sexually assaulted a male victim.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the male adolescent has ever intentionally selected and sexually assaulted a male victim.
<input type="checkbox"/> Not Present	Male adolescent has NEVER intentionally selected and sexually assaulted a male victim.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

13. Diverse sexual-assault behaviours.

<input type="checkbox"/> Present	Adolescent has EVER attempted or engaged in several different contact and/or non-contact sexual-assault behaviours including (but not limited to) exhibitionism, voyeurism, obscene phone calling, stalking, assault with a weapon, frottage, bestiality, sexual touching, or oral, anal, or vaginal penetration.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has ever attempted or engaged in several different contact and/or non-contact sexual-assault behaviours including (but not limited to) exhibitionism, voyeurism, obscene phone calling, stalking, assault with a weapon, frottage, bestiality, sexual touching, or oral, anal, or vaginal penetration.
<input type="checkbox"/> Not Present	Adolescent has engaged in one form of sexual assault behaviour ONLY .
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

14. Antisocial interpersonal orientation.

<input type="checkbox"/> Present	During the past 6 months, the adolescent has exhibited an antisocial interpersonal orientation as evidenced by the presence of 4 or more of the following: <ul style="list-style-type: none"> • Endorsement of antisocial or pro-criminal attitudes • Defiance of authority figures • Insensitive disrespect for the rights / feelings of others • Selfish / self-centered orientation • Difficulty accepting responsibility for most wrongdoings (not just sexual) • Lack of guilt or remorse for most wrongdoings (not just sexual) • Frequent lying and deception • Inflated sense of self-importance and self-worth • Emotionally unresponsive or emotions that appears "faked" • Frequent violations of rules and laws—in addition to sexual assaults(s)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has exhibited an antisocial interpersonal orientation (just 2 or 3 of the above) during the past 6 months.
<input type="checkbox"/> Not Present	Adolescent has NOT exhibited an antisocial interpersonal orientation during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

15. Lack of intimate peer relationships / Social isolation.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent's social relationships have been characterized by: <ul style="list-style-type: none"> • No emotionally intimate peer relationships (peers are non-familial individuals who are within 3 years of age from the adolescent), OR • No close friendships OR reliance on a single peer-aged friend, OR • Social isolation from peers outside of the regular school day.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has had no emotionally intimate peer relationships, relied on a single peer friendship, and/or was socially isolated from peers outside of the regular school day.
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent HAS had emotionally intimate peer relationships, or 2 or more close friends, and/or has not been socially isolated from peers outside of the regular school day.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

16. Negative peer associations and influences.

<input type="checkbox"/> Present	On more than 1 occasion within the past 6 months, the adolescent has associated with peers who: <ul style="list-style-type: none"> • Often engage in antisocial / criminal activity, OR • Often use non-prescription drugs and/or alcohol, OR • The adolescent frequently engaged in antisocial / criminal behaviours to "fit in" or "belong" with a peer group
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, on more than 1 occasion within the past 6 months, the adolescent has associated with peers who: <ul style="list-style-type: none"> • Often engage in antisocial / criminal activity, OR • Often use non-prescription drugs and/or alcohol, OR • The adolescent frequently engaged in antisocial / criminal behaviours to "fit in" or "belong" with a peer group
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT associated with peers who often engage in antisocial / criminal activity or substance use / abuse behaviours on more than 1 occasion.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

17. Interpersonal aggression.

<input type="checkbox"/> Present	During the past 6 months, the adolescent has demonstrated a pattern of interpersonal aggression, characterized by a number of verbally or physically abusive behaviours directed towards people.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has demonstrated a pattern of interpersonal aggression, characterized by a number of verbally or physically abusive behaviours directed towards people.
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT demonstrated a pattern of interpersonal aggression characterized by a number of verbally or physically abusive behaviours directed towards people.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

18. Recent escalation in anger or negative affect.

<input type="checkbox"/> Present (please note) <input type="checkbox"/> Anger <input type="checkbox"/> Negative affect	At any time within the past 6 months, the adolescent has demonstrated an escalation in: <ul style="list-style-type: none"> Anger (e.g., tantrums, verbal or physical aggression, threats), OR Negative affect such as depression, anxiety, loneliness, boredom, or frustration NOTE: this factor represents ONLY an escalation, or heightening, of anger or negative affect—NOT merely the presence of anger or negative affect
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has demonstrated an escalation in: <ul style="list-style-type: none"> Anger (e.g., tantrums, verbal or physical aggression, threats), OR Negative affect such as depression, anxiety, loneliness, boredom, or frustration
<input type="checkbox"/> Not Present	NO escalation in anger or negative affect during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

19. Poor self-regulation of affect and behaviour (Impulsivity).

<input type="checkbox"/> Present	During the past 6 months, the adolescent has demonstrated very poor self-regulation of affect and behaviour. Impulsivity is demonstrated by 3 or more of the following: <ul style="list-style-type: none"> Frequent difficulty delaying gratification Frequent difficulty delaying responses ("blurting out answers") Frequently interrupting others Frequent failure to listen to instructions or directions Frequently becoming bored easily with routine Frequent grabbing or touching things/others without permission Frequent failure to consider consequences before engaging in activities (particularly potentially dangerous or risky activities)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has demonstrated very poor self-regulation of affect and behaviour—is typically highly impulsive (2 or fewer of the above).
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT demonstrated very poor self-regulation of affect and behaviour—is typically NOT impulsive.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

20. High-stress family environment.

<input type="checkbox"/> Present	At any time within the past 6 months, REGARDLESS of where the adolescent has been living, there has been an extreme level of stress within the family as evidenced by issues such as: <ul style="list-style-type: none"> Marked marital discord Death of a family member Separation of a family member from family Major illness of a family member Significant family change in residence, employment, or income Poverty Criminal activity of family member other than adolescent Sexual or physical victimization within the family (not including the adolescent's index sexual offense) Highly conflictual family relationship(s) (OTHER THAN offender-parent relationship)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent's family has experienced high levels of stress at any time within the past 6 months.
<input type="checkbox"/> Not Present	Adolescent's family has NOT experienced high levels of stress during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

21. Problematic parent-offender relationships / Parental rejection.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent has experienced an extremely problematic parent-child relationship as evidenced by: <ul style="list-style-type: none"> • Adolescent feeling rejected, unloved, or unwanted by a parent(s) • Parent's current use of harsh/punitive verbal or physical discipline • Very low level of parental involvement; particularly if the parent was once more involved in the adolescent's life • Significant parent-child conflict / disagreement
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent has experienced an extremely problematic parent-child relationship or has felt rejected, unloved, or unwanted by a parent(s).
<input type="checkbox"/> Not Present	During the past 6 months, the adolescent has NOT experienced an extremely problematic parent-child relationship or has NOT felt rejected, unloved, or unwanted by a parent(s).
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

22. Parent(s) not supporting sexual-offense-specific assessment / treatment.

<input type="checkbox"/> Present	At any time within the past 6 months, the adolescent's parent(s) has not been supportive of sexual-offense-specific assessment/treatment for their child as evidenced by one or more of the following: <ul style="list-style-type: none"> • Parental refusal to participate in assessment/treatment • Parental refusal to allow child to participate in assessment/treatment • Parent(s) denies that their child committed the sexual assault despite evidence to the contrary • Parent(s) denies that there is ANY risk of sexual reoffense • Parent(s) attempts to undermine or minimize the adolescent's sexual-offense-specific assessment/treatment
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at any time within the past 6 months, the adolescent's parent(s) has not been supportive of sexual-offense-specific assessment/treatment for their child.
<input type="checkbox"/> Not Present	Adolescent's parent(s) HAS been supportive of sexual-offense-specific assessment/treatment for their child during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

23. Environment supporting opportunities to reoffend sexually.

<input type="checkbox"/> Present	At the present time—or at any time within the NEXT 6 months—the adolescent is residing in, or often visiting, an environment that supports opportunities to reoffend sexually as evidenced by one or more of the following: <ul style="list-style-type: none"> • Unsupervised access to potential and/or past victims • Poor monitoring or control of adolescent's whereabouts • Adult denial of adolescent's risk to reoffend sexually • Lack of adult awareness of adolescent's high-risk factor(s) • Easy access to sexual media (pictorial, auditory, or textual) • Exposure to frequent sexual behaviours, gestures, or conversations • Supervising adults who blame the victim(s) for the adolescent's offense(s)
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, at the present time—or at any time within the NEXT 6 months—the adolescent is residing in, or often visiting, an environment that supports opportunities to reoffend sexually.
<input type="checkbox"/> Not Present	BOTH presently AND during the NEXT 6 months, the adolescent will NOT be residing in, or often visiting, an environment that supports opportunities to reoffend sexually.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

24. No development or practice of realistic prevention plans/strategies.

<input type="checkbox"/> Present	During the past 6 months: <ul style="list-style-type: none"> The adolescent has not developed a realistic plan to cope with potentially high-risk factors for a sexual reoffense (such as deviant sexual arousal), OR The adolescent has not practiced realistic strategies to cope with potentially high-risk factors. NOTE: "realistic" plans/strategies are those that would be considered sensible, practical, and socially acceptable.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that, during the past 6 months, the adolescent has not developed or practiced realistic strategies to cope with potentially high-risk factors for a sexual reoffense (such as deviant sexual arousal).
<input type="checkbox"/> Not Present	Adolescent HAS BOTH developed AND practiced at least some realistic plan(s) to cope with high-risk factors for a sexual reoffense during the past 6 months.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

25. Incomplete sexual-offense-specific treatment.

<input type="checkbox"/> Present	Adolescent has not yet completed a majority (i.e., 75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Possibly or Partially Present	Possible or partial evidence that the adolescent has not yet completed a majority (i.e., 75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Not Present	Adolescent HAS completed a majority (75% or more) of the sexual-offense-specific treatment goals that were recommended following assessment.
<input type="checkbox"/> Unknown	Insufficient information to support a decision regarding this risk factor.

26. Other factor : _____

<input type="checkbox"/> Present	
<input type="checkbox"/> Possibly or Partially Present	

This is a **SUMMARY** sheet **ONLY**.
VALID ONLY IF ratings have been transferred from Coding Form attached.
 Name of Adolescent and Date of Assessment are noted on Page 1

High Risk Factors for Sexual Reoffense	Present	Partially/Possibly Present	Not Present	Unknown
Sexual Interests, Attitudes, and Behaviours				
1. Deviant sexual interests (younger children, violence, or both)				
2. Obsessive sexual interests/Preoccupation with sexual thoughts				
3. Attitudes supportive of sexual offending				
4. Unwillingness to alter deviant sexual interests/attitudes				
Historical Sexual Assaults				
5. Ever sexually assaulted 2 or more victims				
6. Ever sexually assaulted same victim 2 or more times				
7. Prior adult sanctions for sexual assault(s)				
8. Threats of, or use of, violence/weapons during sexual offense				
9. Ever sexually assaulted a child				
10. Ever sexually assaulted a stranger				
11. Indiscriminate choice of victims				
12. Ever sexually assaulted a male victim (<i>male offenders only</i>)				
13. Diverse sexual-assault behaviours				
Psychosocial Functioning				
14. Antisocial interpersonal orientation				
15. Lack of intimate peer relationships / Social isolation				
16. Negative peer associations and influences				
17. Interpersonal aggression				
18. Recent escalation in anger or negative affect				
19. Poor self-regulation of affect and behaviour (Impulsivity)				
Family/Environmental Functioning				
20. High-stress family environment				
21. Problematic parent-offender relationships/Parental rejection				
22. Parent(s) not supporting sexual-offense-specific assessment/treatment				
23. Environment supporting opportunities to reoffend sexually				
Treatment				
24. No development or practice of realistic prevention plans/strategies				
25. Incomplete sexual-offense-specific treatment				
Other Factor				
Overall Risk Rating <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High				

Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)

Manual

Robert Prentky, Ph.D.
Sue Righthand, Ph.D.

2003

NCJ 202316

Printed copies of this manual are available from the Office of Juvenile Justice and Delinquency Prevention's Juvenile Justice Clearinghouse. To order, call 800-851-3420 and ask for NCJ 202316.

Contact Information

The J-SOAP-II is an experimental scale and is the subject of ongoing research to improve reliability and further enhance predictive validity. We appreciate feedback from users about areas of ambiguity and ways to increase clarity. We are available to answer questions concerning the use of the J-SOAP, updates on validity studies, and training opportunities.

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Introduction

The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) is a checklist whose purpose is to aid in the systematic review of risk factors that have been identified in the professional literature as being associated with sexual and criminal offending. It is designed to be used with boys in the age range of 12 to 18 who have been adjudicated for sexual offenses, as well as nonadjudicated youths with a history of sexually coercive behavior.

Decisions about reoffense risk should not be based exclusively on the results from J-SOAP-II. J-SOAP-II should always be used as part of a comprehensive risk assessment. Like any scale that is intended to assess risk, J-SOAP-II requires ongoing validation and possible revision, as we learn more about how J-SOAP-II works and about how best to assess the risk of youths who have sexually offended. Because the revised J-SOAP is a new scale, and we are just beginning to collect predictive validity data on it, we cannot provide users with cut-off scores for categories of risk at this point; this is all the more reason why scores from J-SOAP-II should not be used in isolation when assessing risk.

Caveat

When assessing risk with sex offenders in general, and with juveniles in particular, the stakes are often very high. In assessing the risk posed by a juvenile, we have an enormous burden of responsibility. Decisions based on our evaluations can have a profound impact: on the one hand, protecting society from genuinely high-risk youths, while on the other hand, possibly resulting in severe, life-altering consequences for low-risk youths.

It is imperative that clinicians who assess the risk of adolescent offending be very knowledgeable of the challenges involved in assessing this population. Unlike adults, adolescents are still very much “in flux.” No aspect of their development, including their cognitive development, is fixed or stable. In addition, their life circumstances often are very unstable. In a very real sense, we are trying to assess the risk of “moving targets.” Since risk status may change, sometimes dramatically, in a brief period of time, we strongly recommend that youths be re-assessed for risk at a minimum of every 6 months. At the very least, Scales 3 and 4 should be rescored every 6 months. Re-assessments should be done even more frequently if the examiner is aware of risk-relevant changes that have occurred in the youth’s life.

Prior to using J-SOAP-II, users should have training and experience in assessing juveniles who commit sexual offenses and risk assessment in general, particularly as it pertains to juvenile sex offending. In addition, prior to using J-SOAP-II, users should read the manual and be familiar with its contents. Before using the scale in any professional capacity, users should complete several practice cases and compare their scores with others who have scored the same case to identify and resolve any scoring difficulties. It is also recommended that J-SOAP-II users periodically consult with each other about their scoring and stay current with the evolving literature relevant for assessing juveniles who sexually offend.

Development and Validation of J-SOAP-II

Development

The original version of this risk assessment scale for juvenile sex offenders was developed at Joseph J. Peters Institute (JJPI) in Philadelphia in 1994 (Prentky, Harris, Frizzell, & Righthand, 2000). The risk assessment variables were developed after reviews of the literature that covered five areas: (1) clinical studies of juvenile sex offenders, (2) risk assessment/outcome studies of juvenile sex offenders, (3) risk assessment/outcome studies of adult sex offenders, (4) risk assessment/outcome studies from the general juvenile delinquency literature, and (5) risk assessment studies on mixed populations of adult offenders.

In all, 23 items representing 4 subscales were developed. These scales were intended to capture the two major historical (static) domains that are of importance for risk assessment with this population (Scale 1: Sexual Drive/Sexual Preoccupation and Scale 2: Impulsive, Antisocial Behavior), and the two major dynamic areas that could potentially reflect behavior change (Scale 3: Clinical/Treatment and Scale 4: Community Adjustment). The latter two subscales were of particular importance, because the original risk assessment protocol was developed to assess not only risk at discharge but change as a function of treatment.

No *a priori* item weighting was used. All items were trichotomized and assumed, for lack of empirical data to suggest otherwise, to be of equal importance. Trichotomization was intended to be a compromise, adding some increase in sensitivity over a simple rating of present/absent, while at the same time preserving acceptable interrater reliability. The coding for each item provided, to whatever extent possible, behavioral anchors to increase clarity and reliability.

Validation

The construction/validation sample consisted of 96 juvenile sexual offenders, ranging in age from 9 to 20 (average age was 14), who were referred to JJPI for assessment and treatment. The risk assessment protocol was completed on all 96 juvenile sex offenders as part of a comprehensive intake battery at JJPI. The protocol was completed again at time of discharge, on average 24 months later. The protocol was coded independently by two clinicians entirely from archival documents and data obtained from the intake battery. After the ratings were completed, the clinicians discussed disagreements, and the agreed-upon ratings were used to examine outcome.

Twelve-month follow-up data were obtained on 75 of the 96 youths in the study. The short-term [12-month] recidivism rate of 11% included three youths that committed another sexual offense, four youths that committed a nonsexual victim-involved offense, and one youth who committed a nonsexual, victimless offense.

The inter-rater reliability (IRR) for all items, except for Caregiver Instability, was good to excellent, ranging from .75 to .91, with an average IRR of .83. The reliability for Caregiver Instability was poor (.59), and that item has since been revised. Three of the subscales had moderate internal consistency, with alphas ranging from .68 to .73. The Clinical/Treatment scale had a high degree of

internal consistency (.85). Three of the four subscales comprised items with high item-total correlations ($r \geq .30$). Seven of the 9 items in Scale 2, 4 of the 5 items in Scale 3, and all items in Scale 4 exceeded this benchmark. The exception was Scale 1. The only Scale 1 item with a reasonably high item-total correlation was Prior Charged Sex Offenses.

Overall, there was an average total scale score of 21 for those juveniles who did not reoffend and an average scale score of 30 for those 3 juveniles who committed another sexual offense. These results were based on a very small sample of eight recidivists, only three of whom were sexual recidivists. For that reason we applied no inferential statistics, and observed group differences were not confirmed by statistical significance.

We looked at Treatment Outcome (assessed at time of discharge) in two ways, by correlating the total score for the six treatment outcome variables with the four follow-up variables and with the four subscales. The correlation between Treatment Outcome and the total scale score was .58. The correlations between Treatment Outcome and the two dynamic subscales were .62 for Clinical/Treatment and .43 for Community Adjustment. The correlations between Treatment Outcome and Follow-Up were .35 for the juveniles who reoffended and .55 for the juveniles who were removed from the community and placed.

This study was informative in pointing to areas that required revision and clarification. The scoring criteria for every item were carefully examined for ambiguity and behavioral examples and anchors were added. Two changes were made to Scale 1. First, the Scale 1 item that included offense planning (History of Predatory Behavior) was replaced with a more clearly defined Offense Planning item. The new Offense Planning item was behaviorally anchored and easier to code from file data than the more inferential History of Predatory Behavior item that required difficult judgments about behaviors such as grooming and exploitation. Second, a fifth variable was added to Scale 1 that was intended to capture the degree to which the juvenile sexualized his victims (for example, use of pornography in the offense, filming the victim, engaging in unusual or ritualized sexual acts with the victim). Two changes were also made to Scale 2. A Juvenile Antisocial Behavior item was added that was intended to assess general delinquency, and a History of Expressed Anger item was added that was designed to assess disruptions due to poorly controlled and poorly managed anger.

The revised scale, completed in 1998 and referred to as J-SOAP, was examined with a sample of 153 juveniles in Maine (Righthand, Prentky, Hecker, Carpenter, & Nangle, 2000). The juvenile sexual offenders in this sample had an average age of 16, and had been adjudicated for a sex offense or had been adjudicated for another offense, but had a documented sex offense in their records. The victims ranged in age from 1 year to 36 years, with an average age of 8.6 years. Inter-rater reliabilities for the four subscales ranged from .80 to .91. Internal consistency continued to be quite high for Scale 2 ($\alpha = .88$), Scale 3 ($\alpha = .95$), and Scale 4 ($\alpha = .80$), with Scale 1 evidencing moderate internal consistency ($\alpha = .64$).

We looked at the factor structure of the 26 items comprising the J-SOAP using principal component analysis (PCA) (Righthand et al., 2000). The four-factor solution provided strong empirical support for the four J-SOAP scales. The first factor, accounting for slightly over 20% of the variance, was the equivalent of Scale 2 (Impulsive, Antisocial Behavior) on J-SOAP. The first factor mapped

Scale 2 precisely, with all items on Scale 2 falling on it. The loadings for these 11 items ranged from .44 to .77. The second factor, also accounting for 20% of the variance, was the equivalent of Scale 3 (Clinical Intervention) on J-SOAP. All five Scale 3 items loaded on this factor along with one item (Quality of Peer Relations) that was from Scale 4 of J-SOAP. The loadings for the five Scale 3 items ranged from .83 to .88. The third factor, accounting for about 9% of the variance, was the precise equivalent of Scale 1 (Sexual Drive & Preoccupation) on the J-SOAP. All five Scale 1 items loaded on this factor, with item loadings ranging from .51 to .72. The fourth factor, accounting for about 8.5% of the variance, was the equivalent of Scale 4 (Community Adjustment) on the J-SOAP. Four of the five Scale 2 items loaded on this component, with item loadings ranging from .46 to .78.

The concurrent validity of the J-SOAP was explored by examining how well it correlated with the Youth Level of Service/Case Management Inventory (LSI/CMI) (Righthand et al., 2000). In addition, we examined the relationship between the J-SOAP static scales (Scales 1 & 2) and criminal history variables coded from the juvenile's files. The coded variables were: (1) Total Offenses, the total number of offenses of any type committed by the youth, (2) Sexual Offenses, the total number of sexual offenses committed by the youth, (3) Sex Offense Victims, the number of victims of contact sexual offenses; and (4) Sexual Aggression, the degree of aggression displayed by the youth during any and all sexual activities throughout his life.

The LSI/CMI was highly correlated with the total J-SOAP score [$r = .91$], as well as the individual scales: Scale 1 [$r = .37$]; Scale 2 [$r = .81$]; Scale 3 [$r = .88$]; Scale 4 [$r = .91$]. Scale 1 was uncorrelated with Total Offenses [$r = .08$] but significantly correlated with Number of Sex Offenses [$r = .36$], Number of Sex Offense Victims [$r = .64$], and Degree of Sexual Aggression [$r = .27$]. Scale 2 was uncorrelated with Number of Sex Offenses ($r = .03$) but significantly correlated with Total Offenses [$r = .30$], Number of Sex Offense Victims [$r = .27$], and Degree of Sexual Aggression [$r = .29$].

Of the original sample of 153 youths, 134 could be reliably coded as to placement, either residential (a treatment or correctional facility) or in the community. The validity of the J-SOAP was also examined by comparing 45 residential and 89 community juveniles on J-SOAP scales (Righthand, Carpenter, & Prentky, 2001). Since Scale 4 is not scored for youths who have been in secure care for 6 months or longer, Scale 4 was not examined. The other three J-SOAP scales discriminated between the two groups, with the residential juveniles being significantly higher in risk than the community juveniles on all three scales.

In one of two recent predictive validity studies, Hecker, Scoular, Righthand, & Nangle (2002) examined juvenile and adult arrest and conviction data for a period spanning 10 to 12 years on a sample of 54 male adolescent sex offenders. Twenty of the juveniles committed a nonsexual offense (37%) and 6 of the juveniles committed a sexual offense (11%) during the follow-up period. Although the total J-SOAP score was not correlated with sexual recidivism, Scale 1 alone significantly improved the prediction of sexual recidivism above chance (ROC, AUC = .79). A serious caveat, however, is that there were only 6 sexual recidivists. The very low rate of sexual recidivism has been a methodological impediment that has hindered our ability to examine in greater depth the predictive validity of J-SOAP.

Waite, Pinkerton, Wieckowski, McGarvey, & Brown (2002) reported on a 9-year follow-up study of 253 very high-risk juvenile sex offenders. Although the detected rate of sexual recidivism was, once again, very low (4.3%, 11 youths were arrested for a new sexual offense), roughly 60% of the sample was arrested for other offenses. Using a modified Scale 2 from the J-SOAP (8 of the 11 items were coded), the juveniles were split into two groups: Low Impulsive/Antisocial ($n = 118$) and High Impulsive/Antisocial ($n = 135$). The proportion of the Low and High groups arrested for any new offense was 52.6% and 74.8%, respectively ($p < .001$). Although the numbers were very small, it is noteworthy that the High Scale 2 juveniles were three times more likely to be rearrested for a new sexual offense (9.8%, compared with 2.9% for the Low Scale 2 juveniles).

Righthand, Knight, and Prentky (2002) tested four theoretical models using structural equation modeling. This study explored (a) the relationship of antecedent adverse life experiences to J-SOAP Scales 1, 2, and 3, and (b) the relationship of J-SOAP to sex offense outcome variables. The six key findings from this study were: (1) there was a strong relationship between a history of sexual abuse and J-SOAP Scale 1, (2) the severity of the sexual abuse was the most important facet of sexual abuse for predicting outcome, (3) family violence/trauma and caregiver instability were both related to J-SOAP Scale 2, (4) J-SOAP Scale 1 was strongly related to the number of victims (the higher the score, the greater the number of victims) and victim gender (higher Scale 1 scores were associated with male victims), (5) J-SOAP Scale 2 was related to victim age (higher Scale 2 scores were associated with older victims (teenage or older)), and (6) J-SOAP Scales 1 and 2 both were associated with the amount of force used in the sexual offenses.

J-SOAP-II

The J-SOAP was revised again based on the results of the studies just described. In addition, an attempt was made to better anchor items in clear, behavioral terms. In this section, we will highlight the most important changes that have been made to J-SOAP. Only substantial changes, such as item additions and deletions, are described here. Because numerous, more subtle changes were made to item wording and scoring criteria, it is important to read over the revised scale carefully.

Scale 1. Six substantial changes were made. These changes include the addition of four new items, the deletion of one item, and an extensive revision of another. The decision to add several items was based on weaknesses in Scale 1 and recent research suggesting the potential importance of these items in assessing the risk of sexual reoffending. The four new items are: (1) Number of Sexual Abuse Victims, which measures the number of victims the juvenile has ever sexually abused, (2) Male Child Victim, which assesses the juvenile's history of sexually abusing a substantially younger male child, (3) Sexualized Aggression, which assesses the presence of gratuitous or expressive aggression that goes beyond what was required to complete the sexual offense, and (4) Sexual Victimization History, which assesses the juvenile's own history of sexual victimization and the complexity and severity of the abuse.

The deleted item is: High Degree of Sexualizing the Victim. This item had a very low frequency of occurrence and appeared of limited utility. One item, Evidence of Sexual Preoccupation/Obsessions, was replaced with a more clearly defined Sexual Drive and Preoccupation item. The new Sexual Drive and Preoccupation item was behaviorally anchored with a range of examples making it easier to code from file data. Scale 1 in the J-SOAP-II now has a total of eight items.

Scale 2. Six substantial changes were made. (1) Two items, History of Substance Abuse and History of Parental Substance Abuse, were eliminated. Several studies consistently indicated that these were weak items and were not contributing to the predictive ability of Scale 2. (2) The item School Suspensions or Expulsions was combined with the item School Behavior Problems to reduce the obvious overlap between those two items. (3) The item Impulsivity was dropped. As a risk predictor, lifestyle impulsivity appears to be more effective with adults than juveniles. The J-SOAP item, Juvenile Antisocial Behavior, provides a much better assessment of impulsivity in adolescence. (4) An item, Physical Assault History/Exposure to Family Violence, was added based on the empirical literature as well as our recent path analysis looking at the developmental antecedents of J-SOAP scales, (5) The item Caregiver Consistency was revised. In order to provide a more sensitive assessment of caregiver changes that might impact adversely affect the development of attachments and relationships, the item was changed to assess caregivers prior to age 10 rather than 16. J-SOAP-II Scale 2 now has a total of eight items.

Scale 3. Because J-SOAP-II may be useful for assessing nonsexual recidivism as well as sexual recidivism, relevant Scale 3 Intervention items were revised to include changes in attitudes and behaviors related to nonsexual offending as well as sexual offending. In addition, because empathy and remorse are really distinct attitudes and feelings, J-SOAP item Evidence of Empathy, Remorse, and Guilt was separated into two items, one simply entitled Empathy, and the other entitled Remorse and Guilt. Finally, based on Principal Components Analyses findings, the item Quality of Peer Relationships was moved from Scale 4 to Scale 3, where it appears to fit conceptually as an important target of treatment interventions. These changes result in J-SOAP-II Scale 3, the Intervention Scale, having a total of seven items.

Scale 4. Two substantial changes were made to Scale 4. One new item, Management of Sexual Urges and Desire, was added to assess the extent to which the juvenile manages his sexual urges and desires in socially appropriate and healthy ways. Also, as noted above, the item Quality of Peer Relationships was moved from Scale 4 to Scale 3. These changes resulted in Scale 4 having a total of five items.

In all, the revised scale has 28 items, 2 more than the original J-SOAP. J-SOAP-II replaces all previous versions of the J-SOAP.

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Frequently Asked Questions

1. What is actuarial risk assessment?

“Actuarial” refers to the work done by actuaries. Actuaries are individuals who are trained to calculate risks using statistics, usually for insurance companies. Actuarial scales are developed using statistical analyses of groups of individuals with known outcomes (such as men who have been convicted of a new sex offense and men who apparently have not reoffended sexually). These analyses tell us which items (“predictor variables”) do the best job of differentiating between those who reoffended and those who did not reoffend. Because some items inevitably do a better job than others, these analyses can also tell us how much each item should be weighted. The items are combined to form a scale. The scales are then used on other samples to see how well they work (to test their validity).

2. Is the J-SOAP an actuarial scale?

Although our goal is to provide the user with probabilistic estimates of risk for sexual recidivism, we still do not have adequate data on a sufficiently large number of juvenile sexual reoffenders to provide such estimates. Thus, at the present time, J-SOAP-II is not an actuarial scale. J-SOAP is an empirically informed guide for the systematic review and assessment of a uniform set of items that may reflect increased risk to reoffend.

3. Why are there no cut-off scores?

Cut-off scores are determined after many subjects have been scored and a large and diverse database is available. Most importantly, this database must include excellent followup information on sexual recidivism (those who have reoffended and those who have not). Rather than assigning cut-off scores based on insufficient information, we decided that the most prudent and responsible approach was to recommend the use of ratios. The score of each scale can be divided by the total possible score for that scale. The total J-SOAP-II score can also be reported as a ratio. These ratios or proportions reflect the observed “amount” of risk rated as present for each scale and for the total score. When the data that are being gathered clearly point to reliable cut-off scores with diverse samples of juveniles, we will recommend those cut-offs to users.

4. What about item weighting?

Actuarial scales may work better when items are properly weighted. Item weighting takes into consideration that some items simply are more important than others when it comes to predicting outcome. Proper item weighting is done with a statistical procedure called multiple linear regression. The result is a “weighted linear prediction.” Item weighting, however, is not required. Some argue that simple unit item weighting (the way the J-SOAP works) is just as effective.

This is, of course, an empirical question. In order to do proper item weighting, large samples of offenders are needed to determine the item weights, and we have not as yet gathered enough outcome data to examine the potential increase in accuracy using item weights.

At the present time, the J-SOAP is a simple unit weighted system. We add the scores for all of the items and divide by the total possible score to derive the proportion rated as present. Although this procedure may not be as effective as using item weights, it is superior to using clinically derived weights (clinical notions about how the items should be weighted, unsupported by any data).

5. Can I “adjust” the J-SOAP score?

This question is most relevant for discussions of actuarial risk assessment instruments, and, as noted above, the J-SOAP-II is not an actuarial instrument. Users might adjust a J-SOAP score by changing the way they rated a particular item because the score was not consistent with their impression of the juvenile. They would, in effect, be changing the criteria for scoring that item, and that is not acceptable. The scores for individual items, as well as the overall scale scores, should never be changed or adjusted. “Adjustment” is perfectly legitimate when writing up conclusions about the juvenile’s risk. In that context, you would be “adjusting” your conclusions, presumably based on risk-relevant information that the J-SOAP-II did not take into consideration, and not adjusting the J-SOAP-II scores. We might think of such risk-relevant information in the dynamic sense, as mitigating or aggravating factors that serve to increase or decrease risk. The clinician could report, for example, “Although the J-SOAP-II score is relatively low, there are clear aggravating factors in the individual’s life that may increase his risk . . .”

6. What can I do to improve my scoring reliability?

The single most important factor contributing to unreliability is the lack of information or the ambiguity of information being used to score the item. How incomplete or how ambiguous the information is may vary enormously from one case to another, and there are no simple or easy methods for dealing with this problem. In general, multiple sources of information are ideal. Not only is there a greater likelihood of finding needed information, but multiple sources provide a cross-check of the information.

To enhance reliability, we strongly recommend that examiners use as many sources of information as possible when scoring J-SOAP-II. In addition, although it is often not feasible, we also recommend that the J-SOAP-II be scored by two independent clinicians who then compare and discuss their scores. The agreed-upon scores should be used. When the available information is very limited, unclear, or incomplete, items should be scored “conservatively” (that is, in the direction of lower risk), and it should be noted that the resulting score may underestimate the risk.

Clinicians should, of course, study the manual before using J-SOAP-II. Lastly, it is strongly recommended that users of J-SOAP-II complete several training cases before using the J-SOAP on a real case. The importance of adequate training on practice cases cannot be overstated.

7. How can I use J-SOAP scores in treatment planning?

As noted previously, the purpose of the J-SOAP-II is to facilitate risk assessment and risk management. J-SOAP-II may be particularly useful for informing and guiding treatment and risk management decisions. For example, if a youth has a relatively high score on Scale 1 but a

relatively low score on Scale 2, the youth may require more sex offense-specific treatment interventions and less of a focus on delinquency interventions. In fact, mixing such a youth with more “hard-core” delinquents may do more harm than good.

In contrast, a youth who has a relatively high score on Scale 2 but a relatively low score on Scale 1 may have sexually offended as part of a more general pattern of antisocial behavior. In cases such as this, the sexual offense may not reflect serious issues involving management of sexually deviant or sexually coercive behavior. This type of youth may require delinquency-focused treatment interventions, perhaps with some limited psychoeducational interventions that address appropriate sexual boundaries, nonabusive sexual behavior, impulse control, and healthy masculinity.

Juveniles who have high scores on Scale 1 and Scale 2 may well require more intensive supervision, perhaps in a secure residential placement, and need sex-offense specific treatment as well as delinquency-focused interventions. Low scores on Scales 1 and 2, on the other hand, may suggest that the offending behavior was more situational and requires only limited interventions, such as psychoeducational approaches that address human sexuality, appropriate sexual behavior, social skills training and dating skills. Specific interventions, of course, depend on the overall picture of risk and needs.

Scoring Guidelines

The J-SOAP-II items are scored using a 0 to 2 scale, with 0 always associated with the apparent absence of the item and 2 always associated with the clear presence of the item. Thus, “0” implies the apparent absence of the risk factor described by the item, and “2” implies the clear presence of the risk factor as described by the item. A score of “1” implies the presence of some information that suggests the presence of the item, but the information is insufficient, unclear, or too sketchy to justify a score of “2.”

As noted in FAQ 6, to enhance accuracy and reliability, assessments should be based on multiple sources of information whenever possible. Unless otherwise noted in the item description, scores should be based on all available evidence, including self-report, and documentation in the records. If available information is limited, incomplete, or unclear, items should be scored in the direction of lower risk (favoring the absence rather than the presence of the item), and it should be noted that the resulting scores may be underestimates. As previously noted, J-SOAP-II is not an exhaustive list of risk variables and is not a substitute for assessing other potentially risk-relevant variables on a case-by-case basis.

Scores are obtained by summing the items on each of the four scales and then adding the four scale scores to derive the overall J-SOAP-II score. Each scale score is then divided by the total possible score for that scale to determine the relative “proportion of risk” rated as present for each of the four scales. For example, if the total for all eight items on Scale 2 was 8, the Scale 2 score would be reported on the Summary Form as 50% (8/16). Similarly, the overall J-SOAP-II score is divided by the total possible score (i.e., 28 items x 2 points each = 56).

Scoring Instructions

Section I. Static Risk Assessment

Scale 1. Sexual Drive/Preoccupation Items

Item 1: Prior Legally Charged Sex Offenses

Description: This item is simply the total number of prior charged sexual offenses that involved physical contact. Conviction is not necessary. Do not count the current, governing, or index sexual offense(s).

Scoring:

0 = None.

1 = 1 offense.

2 = More than 1 offense.

Item 2: Number of Sexual Abuse Victims

Description: This item looks at the number of victims the juvenile is known to have ever sexually abused. In making this judgment, use any reliable source. A legal charge/conviction is not required. “Victim” is defined as anyone who has been sexually abused in a manner involving physical contact.

Scoring:

0 = Only 1 known victim.

1 = 2 known victims.

2 = 3 or more known victims.

Item 3: Male Child Victim

Description: This item assesses the juvenile's history of sexually abusing a male child. A "child" victim is defined here as someone who is 10 years old or younger and is at least 4 years younger than the juvenile. If the juvenile was age 14 or older at the time of the offense, the victim was 10 or younger. If the juvenile was 13, the victim was 9 or younger. If the juvenile was 12, the victim was 8 or younger. If the child victim was older than 10, this item may still be scored if there was clear evidence of physical force or violence.

Scoring:

0 = No known male child victims.

1 = 1 male victim (only 1 known).

2 = 2 or more known male victims.

Item 4: Duration of Sex Offense History

Description: This item looks at the total amount of time the juvenile has been known to commit sexual contact offenses (i.e., from the first known sexual contact offense to the current [governing or index] sexual contact offense). In making this judgment, include all credible reports and self-report. Do not limit scoring to legally charged offenses.

Scoring:

0 = Only 1 known sexual offense and no other history of sexual aggression (i.e., the governing or index offense is the only known sexual offense).

1 = There are multiple sex offenses within a brief time period (6 months or less). The multiple sex offenses may involve multiple assaults on the same victim or multiple victims.

2 = There are multiple sex offenses that extend over a period greater than 6 months and involve 1 or more victims.

Item 5: Degree of Planning in Sexual Offense(s)

Description: This item looks at the degree of forethought, planning, and premeditation that took place prior to the sexual assaults. It concerns the individual's modus operandi (MO): everything the individual did to commit the offense. In general, the more detail and forethought involved in planning an offense, the more complex the MO. With highly impulsive, opportunistic offenses, the MO will be negligible. When there are multiple known sexual assaults, score for the assault that reflects the greatest degree of planning. This item should also be scored when a high degree of manipulation and deception has been used to gain access to the victim's.

Scoring:

- 0 = No planning. All known sexual offenses appear to have been impulsive, opportunistic, sudden, and without any apparent forethought prior to the encounter.
- 1 = Mild degree of planning. Some clear evidence that the individual thought about or fantasized about the sexual offense before the encounter. Some degree of grooming or "setting up" the victim may reflect mild planning.
- 2 = Moderate-Detailed planning. There must be a clear modus operandi. The offenses may appear "scripted," with a particular victim and crime location targeted. Planning also may be evident when there is a high degree of manipulation and/or a significant amount of grooming to gain access to the victim. The major difference between Mild and Moderate-Detailed planning is the extent and degree of planning and the amount of time invested in planning. The distinction is quantitative rather than qualitative.

Item 6: Sexualized Aggression

Description: This item captures the degree or level of gratuitous or expressive aggression in the sexual offenses. Gratuitous or expressive aggression is aggressive behavior that clearly goes beyond what was required to complete the sexual offense.

Scoring:

- 0 = No gratuitous or expressive aggression. No evidence that the individual intentionally physically hurt the victim or demeaned or humiliated the victim; no evidence that the individual used force or aggression beyond what was required to complete the sexual offense.
- 1 = Mild amount of expressive aggression. For example, as evidenced by swearing or cursing at the victim, threatening the victim, squeezing, slapping, pushing, or pinching the victim.
- 2 = Moderate-High amount of expressive aggression. For example, as evidenced by punching, kicking, cutting, burning, or stabbing the victim; causing physical injuries that require medical attention; or intentionally humiliating or degrading the victim.

Item 7: Sexual Drive and Preoccupation

Description: This item measures “hypersexuality” (i.e., the strength of the sexual drive and preoccupation). This is a behaviorally anchored item that focuses on evidence of an excessive amount of sexual activity (exceeding what might be considered normative for youths of that age) or excessive preoccupation with sexual urges or gratifying sexual needs. Evidence includes, but is not limited to, paraphilias (exposing, peeping, cross-dressing, fetishes, etc.); compulsive masturbation; chronic and compulsive use of pornography; frequent highly sexualized language and gestures; and indiscriminant sexual activity with different partners out of the context of any relationship. Consider all credible and reliable evidence, self-reported as well as documented in the records.

Scoring:

0 = Normative/Minimal. 1 or 2 instances of sexualized behavior.

1 = Moderate. Sexualized behaviors have been observed and noted on 3 to 5 separate occasions.

2 = High. Sexualized behaviors have been observed and noted on 6 or more separate occasions.

Item 8: Sexual Victimization History

Description: This item assesses the juvenile’s own history of sexual victimization. In this context, excessive force refers to force that clearly exceeded what was necessary to gain compliance.

Scoring:

0 = None known.

1 = The juvenile was a victim of sexual abuse. There is no evidence of any form of sexual penetration or excessive force or physical injury to the juvenile.

2 = The juvenile was a victim of sexual abuse. Score 2 if there is evidence of sexual penetration or excessive force or physical injury.

Scale 2. Impulsive/Antisocial Behavior Items

Item 9: Caregiver Consistency

Description: This item measures the consistency and stability of caregivers in the life of the juvenile before the age of 10. Multiple changes in caregivers or changes in living situations with different caregivers and the number of different caregivers are critical. A “change” must last for at least 6 months to be considered (for example, if the individual spends a month living with his aunt and uncle, it would not be considered a change of caregivers).

Scoring:

0 = Lived with biological parents until his current age or until age 10.

1 = 1 or 2 changes in caregivers (e.g., from biological parents to step or foster parents).

2 = 3 or more changes in caregivers before age 10.

Item 10: Pervasive Anger

Description: This item includes (1) repeated instances of verbal aggression and angry outbursts, (2) threatening and intimidating behavior, and (3) nonsexual physical assaults directed at multiple targets across multiple settings—anger directed at parents, peers, police, teachers, animals, etc. The essential point is that the behavior must reflect anger across persons and situations. Although destroying property may be an expression of anger, the destruction of property does not necessarily result from anger.

Scoring:

0 = No evidence.

1 = Mild. Occasional outbursts and inappropriate expressions of anger or a pattern of anger expressed at an apparently narrow range of targets (e.g., anger only expressed at peers).

2 = Moderate-Strong. Long-standing pattern of repeated instances of poorly managed anger directed at multiple targets.

Item 11: School Behavior Problems

Description: Score this item for kindergarten through eighth grade only. School behavior problems include school failure not due to cognitive difficulties. Examples may include chronic truancy, fighting with peers and/or teachers, or other evidence of serious behavioral problems at school that require corrective intervention. Fighting should only be considered if there has been physical contact (e.g., punching, kicking, shoving) and not if there has only been yelling or arguing.

Scoring:

0 = None (no clear evidence of school behavior problems).

1 = Mild (a few apparently isolated instances).

2 = Moderate-Severe (clear evidence of multiple instances of behavior problems that may include behaviors resulting in suspensions or expulsion from school).

Item 12: History of Conduct Disorder Before Age 10

Description: Score this item for behavior before the age of 10. Score for a persistent pattern of behavioral disturbance characterized by (1) repeated failure to obey rules, (2) violating the basic rights of others, and (3) engaging in destructive and aggressive conduct at school, at home, and/or in the community.

Scoring:

0 = No evidence.

1 = Mild-Moderate (1 or 2 different criteria present).

2 = Strong (all 3 criteria present).

Item 13: Juvenile Antisocial Behavior (Ages 10–17)

Description: Score this item for behavior between the ages of 10 and 17. Score for nonsexual delinquent behavior such as: (1) vandalism and destruction to property; (2) malicious mischief, disorderly conduct, vagrancy, habitual truancy; (3) fighting and physical violence; (4) owning or carrying a weapon (other than for sport and hunting); (5) theft, robbery, burglary; and (6) motor vehicle-related (reckless driving, operating to endanger, operating under the influence). Scoring for this item is not limited to legally charged offenses. Consider all credible and reliable evidence, self-reported as well as documented in the records.

Scoring:

0 = None/Minimal (no more than a single incident).

1 = Moderate (2 or 3 different criteria present. Moderate also may be scored if there is a single very serious episode or multiple incidents involving one type of behavior).

2 = Strong (4 or more different criteria present or multiple incidents involving 2 or 3 types of behavior).

Item 14: Ever Charged or Arrested Before the Age of 16

Description: Score current offenses as well as previous charges/arrests for sexual and nonsexual offenses occurring before age 16. The juvenile must have been charged and/or arrested; conviction is not necessary.

Scoring:

0 = No.

1 = Once.

2 = More than once.

Item 15: Multiple Types of Offenses

Description: Scoring for this item is limited to legally charged offenses. Check as many different types of offense categories as apply and score according to the total number of categories checked.

- ☐ a. Sexual Offenses (such as rape, indecent assault, gross sexual assault, unlawful sexual contact, open and gross lewdness).
- ☐ b. Person Offenses—Nonsexual (such as assault, assault and battery, assault causing bodily harm, robbery, kidnapping, attempted murder, manslaughter, murder, terrorizing).
- ☐ c. Property Offenses (such as theft, burglary, possessing burglary tools, larceny, breaking and entering, criminal trespass, malicious destruction of property, arson, receiving/possessing stolen property, embezzlement, extortion of property).
- ☐ d. Fraudulent Offenses (such as fraud, forgery, passing bad checks, using stolen credit cards, impersonation, identity fraud, counterfeiting).
- ☐ e. Drug Offenses (drug trafficking and other clearly drug-related crimes not scored elsewhere; score simple possession of drugs under Conduct Offenses).
- ☐ f. Serious Motor Vehicle Offenses (such as operating to endanger, operating under the influence, reckless driving, chronic speeding, leaving the scene of an accident, vehicular homicide).
- ☐ g. Conduct Offenses (such as disorderly conduct, running away, vagrancy, malicious mischief, possession of alcohol and/or drugs, resisting arrest, habitual truancy, habitual offending).
- ☐ h. Other Rule Breaking Offenses (no clear victim but the law has been broken, such as escape from legal custody, failure to appear, conspiracy, accessory before or after the fact, possession of a firearm without a permit, obstruction of justice, violation of conditions of probation or other release, violation of a protection/ restraining order, prostitution).

Scoring:

0 = 1 type.

1 = 2 types.

2 = 3 or more types.

Item 16: History of Physical Assault and/or Exposure to Family Violence

Description: This item assesses the juvenile's own history of having been physically abused and/or exposed to violence within the home by a caregiver (biological, adoptive, foster, or step family). Exposure to family violence includes visual or auditory exposure to physical assaults on family members. It is not necessary for both physical abuse and exposure to violence to be present to score this item.

Scoring:

0 = No/Unknown.

1 = Yes. There is clear evidence that the juvenile was the victim of physical abuse by any caregiver. The documented history must indicate that the physical injuries did not warrant medical attention. Exposure to violence may include exposure to threats of violence and physical altercations involving pushing, shoving, and slapping, but no injuries requiring medical attention.

2 = Moderate/Severe. The physical abuse was frequent or very severe, resulting in serious injuries ordinarily requiring medical attention, including black eyes, broken bones, and severe bruising. Score for exposure to violence if the exposure was frequent or if the violence was very severe, resulting in serious injuries ordinarily requiring medical attention. The term "ordinarily" reflects the fact that the victims of violence may not receive medical attention but, in your estimation, the severity of the injury deserved such attention.

Section II. Dynamic Risk Assessment

Scale 3. Intervention Items

WHEN RATING THE ITEMS IN SCALE 3, TAKE INTO CONSIDERATION ALL DELINQUENT BEHAVIOR, NOT JUST SEX OFFENDING. IF THE JUVENILE HAS ONLY COMMITTED SEX OFFENSES, SIMPLY RATE ITEMS BASED ON THOSE SEX OFFENSES.

Item 17: Accepting Responsibility for Offense(s)

Description: Accepting full responsibility for one's offense(s) means no redirecting or assigning some or all of the responsibility for the offenses to others (i.e., the individual does not attribute some of the responsibility to the victim, to friends or other kids, to society, the police, the courts, or others). Any statements suggesting other than full responsibility should be scored as 1 or 2.

Scoring:

- 0 = Accepts full responsibility for sexual and nonsexual offenses without any evidence of minimizing.
- 1 = Accepts some (but not total) responsibility. Although occasional minimizing may be present, individual does not deny offending.
- 2 = Accepts no responsibility, or there is full denial. Option 2 also is scored when there is partial denial and/or significant or frequent minimizing.

Item 18: Internal Motivation for Change

Description: The focus of this item is the extent to which the individual truly experiences offending as out of character and appears to have a genuine desire to change his behaviors to avoid any recurrences.

Scoring:

- 0 = Appears distressed by his offenses and appears to have a genuine desire to change.
- 1 = There is some degree of internal conflict and distress, mixed with a clear desire to avoid the "consequences" of reoffending.
- 2 = No internal motivation for change. The juvenile does not perceive a need to change. He may feel hopeless and resigned about life in general, or he may deny ever committing offenses and therefore maintains he does not need to change and/or does not need treatment. Also score 2 if motivation for change is solely external (e.g., to avoid arrest, incarceration, or residential placement).

Item 19: Understands Risk Factors and Applies Risk Management Strategies

Description: This item concerns the individual's knowledge and understanding of factors and situations associated with his offending and the individual's awareness of risk management strategies and utilization of such strategies.

Scoring:

- 0 = Good understanding and demonstration of knowledge of risk factors and risk management strategies. Knows triggers, cognitive distortions (thinking errors), and high-risk situations. Knows and uses risk management strategies.
- 1 = Incomplete or partial understanding of risk factors and risk management strategies. Demonstration of knowledge may be present but inconsistent.
- 2 = Poor or inadequate understanding of risk factors and risk management strategies. Cannot adequately identify triggers, cognitive distortions (thinking errors) and offense-justifying attitudes, high-risk situations, or risk management strategies.

Item 20: Empathy

Description: This item assesses the youth's capacity for empathy in multiple situations. An attempt should be made to distinguish between statements that appear to reflect genuine feelings and statements that are primarily cognitive and reflect attitudes (e.g., socially desirable responses or genuinely held but strictly intellectual statements).

Scoring:

- 0 = Appears to have a genuine capacity for feeling empathy for his sexual abuse victims and can generalize to others in a variety of situations.
- 1 = There is some degree of expressed empathy; however, these statements appear to be internalized at a strictly intellectual level or are intended primarily to "look good" or respond in a socially acceptable way.
- 2 = There is little or no evidence of empathy and clear evidence of callous disregard for the welfare of others.

Item 21: Remorse and Guilt

Description: This item assesses the extent to which the juvenile expresses thoughts, feelings, and sentiments that reflect remorse for offending and offense-related behavior. This item attempts to assess feelings of regret, guilt, or self-reproach. An attempt should be made to distinguish between statements that appear to reflect genuine feelings and statements that are primarily cognitive and reflect attitudes (e.g., socially desirable responses or genuinely held but strictly intellectual statements about “feeling bad”).

Scoring:

- 0 = Appears to have genuine remorse for his victims and can generalize to other victims. Importantly, remorse appears to be internalized at an affective (emotional) level and is expressed or demonstrated without prompting.
- 1 = There is some degree of remorse or guilt; however, there are possible egocentric motives (e.g., shame or embarrassment, to avoid incarceration). Score 1 when the remorse appears to be internalized at a strictly cognitive (thinking) level.
- 2 = There is little or no evidence of remorse for victims.

Item 22: Cognitive Distortions

Description: This item assesses distorted ideas, beliefs, or attitudes that justify sexual offending and delinquent behavior. Examples include “She looked older than she was,” “He started it,” and “I didn’t hurt anyone.” Rate this item only for the presence of distorted attitudes. This item should not be influenced by ratings of item 17 (accepting responsibility) and 21 (remorse or guilt).

Scoring:

- 0 = Expresses no distorted thoughts, attitudes, or statements about sexual offending and delinquent behaviors.
- 1 = Occasional comments, attitudes, or statements reflecting cognitive distortions.
- 2 = Frequent comments, attitudes, or statements reflecting cognitive distortions.

Item 23: Quality of Peer Relationships

Description: This item assesses the nature and quality of the juvenile's peer relationships, the extent to which his time is occupied by nondelinquent social activity, and the extent to which his peer associations are age appropriate and nondelinquent.

Scoring:

- 0 = Socially active, peer-oriented, and rarely alone; often with friends in structured and unstructured social and/or sports activities; friends are nondelinquent.
- 1 = A few casual (nondelinquent) friends, some involvement in structured or unstructured activities; or a mix of social activity with delinquent as well as nondelinquent peers.
- 2 = Withdrawn from peer contact and socially isolated; or no friendships, just "acquaintances"; or most peers are delinquent.

Scale 4. Community Stability/Adjustment Items

SCORE THE REMAINING FIVE ITEMS FOR THE PAST 6 MONTHS. OMIT THIS SECTION IF THE JUVENILE IS INCARCERATED IN A CORRECTIONAL FACILITY OR A SECURE RESIDENTIAL TREATMENT PROGRAM.

- **If a juvenile has recently been discharged from a correctional facility or secure residential treatment program where he has resided for more than 6 months and is now being assessed in the community, he must have been in the community for at least 3 months in order to score these five items.**
- **If the juvenile has been incarcerated or has been placed in a secure residential treatment program, he must have been in the community for at least 2 months prior to incarceration in order to score these five items.**

Item 24: Management of Sexual Urges and Desire

Description: This item assesses the extent to which the juvenile manages his sexual urges and desires in socially appropriate and healthy ways. This item does not assess strength of sexual drive (as in item 7). This item assesses the appropriateness of the individual's sexual behavior. Consider all credible and reliable evidence, self-reported as well as documented in the records. If the governing or index offense occurred within the 6-month window that applies to all Scale 4 items, do not include it when scoring this item.

Scoring:

- 0 = Well-managed expression of sexual urges and desires; all sexual intimate relationships are age appropriate and noncoercive; no evidence of unwanted, sexualized touching or hostile/demeaning sexualized remarks.
- 1 = Sexual urges and desires are managed appropriately most of the time, with no more than two instances of inappropriate sexual behavior.
- 2 = Sexual urges and desires are poorly managed. Juvenile engages in inappropriate sexual behavior, frequently gratifying sexual urges in deviant or paraphilic ways. This behavior has been noted on three or more occasions. Examples might include chronic masturbation or compulsive use of pornography. Score 2 for sexual promiscuity (numerous sexual partners out of the context of a relationship). Any instance of coercive sexual behavior is automatically scored 2 unless it is the governing or index offense.

Item 25: Management of Anger

Description: This item assesses the appropriateness of one's expression of angry feelings.

Appropriate expressions are defined here as verbal, nonabusive, and nonviolent expressions of anger. This item does not assess the "pervasiveness" of one's anger (as in item 10). Rate how well the individual manages and expresses feelings of anger in his relationships, at work and with his friends and acquaintances.

Scoring:

0 = No evidence of inappropriate anger. Anger consistently is expressed in appropriate ways.

1 = Anger managed appropriately most of the time, with no more than four instances of inappropriate anger

2 = Anger poorly and inappropriately managed, with five or more instances of inappropriate anger.

Item 26: Stability of Current Living Situation

Description: This item assesses the stability (or instability) of the living situation where the youth is residing at the time of the assessment. If the juvenile is living with his family (birth, foster, or adoptive), this item assesses family stability and is based on the overall adequacy and consistency of the primary family environment. Consider such factors as size of family, number of relocations, and number of changes in the family due to separations, divorce, death, unemployment, and other losses, as well as additions of new members. Consider substance abuse, pornography use, child abuse and neglect, frequent changes in sexual partners, poor or loose boundaries around sexuality, serious illness, psychiatric difficulties, chronic fighting or angry outbursts, family violence, and/or criminal behavior.

Instability may also be indicated by frequent changes in the juvenile's living situation, or when the juvenile is in a high-risk living situation (such as a shelter) or lives in a high-risk location (e.g., near a bar or a playground). Scoring should reflect the stressfulness of the living situation. Score this item, as appropriate, for youths living in group homes or nonsecure residential settings.

When scoring this item, consider the number of different sources of instability and the frequency of the instability.

Scoring:

0 = Stable. No significant sources of disruption or instability.

1 = Moderate instability. Sources of instability are intermittent. Any very serious sources of instability, even if intermittent, should be scored a 2 (e.g., presence of sexual abuse perpetrated by others or violence in the living situation).

2 = Severe instability. Sources of instability are frequent and chronic occurring at least one or two times a week.

Item 27: Stability in School

Description: This item assesses the stability (or instability) of the youth's behavior in school. For example, instability would be evidenced by truancy, repeatedly coming to school late, suspensions or expulsions, and use of alcohol or drugs at school. If the youth is not in school, score this item for the stability of his day, e.g., the stability of the youth's behavior at work. For the most part, the exemplars of instability are consistent across settings. For example, in the work setting, instability may be evident in failing to come to work, coming to work late, or being fired. If the juvenile is not in school or not in work, score 1.

Scoring:

0 = Stable/Minimal (no more than a single incident).

1 = Unstable (with no more than two or three incidents).

2 = Highly Unstable (with four or more incidents).

Item 28: Evidence of Positive Support Systems

Description: This item considers the relative presence or absence of support systems that the youth has available to him in the community and that he uses for positive support. Support systems may include (1) apparently supportive family members, extended families, foster families, (2) friends, or (3) significant others, such as therapists, juvenile probation officers, and social service caseworkers. Positive supports also may be indicated by participation in (4) organized after-school sports and activities and (5) involvement in organized religious activities.

Scoring:

0 = Considerable support systems (three or more of the above apply).

1 = Some support systems (one or two of the above applies).

2 = No known support systems or only negative supports.

Juvenile Sex Offender Assessment Protocol-II Scoring Form

1. Sexual Drive/Preoccupation Scale

1. Prior Legally Charged Sex Offenses	0	1	2
2. Number of Sexual Abuse Victims	0	1	2
3. Male Child Victim	0	1	2
4. Duration of Sex Offense History	0	1	2
5. Degree of Planning in Sexual Offense(s)	0	1	2
6. Sexualized Aggression	0	1	2
7. Sexual Drive and Preoccupation	0	1	2
8. Sexual Victimization History	0	1	2
<u>Sexual Drive/Preoccupation Scale Total</u>			

2. Impulsive/Antisocial Behavior Scale

9. Caregiver Consistency	0	1	2
10. Pervasive Anger	0	1	2
11. School Behavior Problems	0	1	2
12. History of Conduct Disorder	0	1	2
13. Juvenile Antisocial Behavior	0	1	2
14. Ever Charged or Arrested Before Age 16	0	1	2
15. Multiple Types of Offenses	0	1	2
16. History of Physical Assault and/or Exposure to Family Violence	0	1	2
<u>Antisocial Behavior Scale Total</u>			

3. Intervention Scale

17. Accepting Responsibility for Offense(s)	0	1	2
18. Internal Motivation for Change	0	1	2
19. Understands Risk Factors	0	1	2
20. Empathy	0	1	2
21. Remorse and Guilt	0	1	2
22. Cognitive Distortions	0	1	2
23. Quality of Peer Relationships	0	1	2
<u>Intervention Scale Total</u>			

4. Community Stability/Adjustment Scale

24. Management of Sexual Urges and Desire	0	1	2
25. Management of Anger	0	1	2
26. Stability of Current Living Situation	0	1	2
27. Stability in School	0	1	2
28. Evidence of Positive Support Systems	0	1	2
<u>Community Stability Scale Total</u>			

Juvenile Sex Offender Assessment Protocol-II Summary Form

Static/Historical Scales

1. Sexual Drive/Preoccupation Scale Score: _____/16 = _____
(Add Items 1–8 [range: 0–16])
2. Impulsive-Antisocial Behavior Scale Score: _____/16 = _____
(Add Items 9–16 [range: 0–16])

Dynamic Scales

3. Intervention Scale Score: _____/14 = _____
(Add Items 17–23 [range 0–14])
4. Community Stability Scale Score: _____/10 = _____
(Add Items 24–28 [range: 0–10])

Static Score (Add items 1–16) _____/32 = _____

Dynamic Score (Add items 17–28) _____/24 = _____

Total J-SOAP Score (Add items 1–28) _____/56 = _____



JUSTICE AND PUBLIC SAFETY CABINET

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Governor

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John C. Tilley
Secretary

Raymond F. DeBolt
Commissioner

JUVENILE SEXUAL OFFENDER TRACKING SYSTEM INITIAL REPORTING FORM – PART 1

Youth Name:	Date of Birth:
DJJ Number:	Gender: Select Gender Race: Select Race
County of Commitment:	Date of Completion: <small>Click or tap to enter a date.</small>
Worker:	District: Choose Supervisor:
Date of JSO Assessment:	<small>Click or tap to enter a date.</small> Risk Level: Select Risk Level
Date of RCNA Assessment:	<small>Click or tap to enter a date.</small> Risk Level: Select Risk Level Score: Select Score

Charge(s)	Offense Class	Disposition Date(s)
	Select Offense Type	<small>Click or tap to enter a date.</small>
	Select Offense Type	<small>Click or tap to enter a date.</small>
	Select Offense Type	<small>Click or tap to enter a date.</small>
	Select Offense Type	<small>Click or tap to enter a date.</small>
	Select Offense Type	<small>Click or tap to enter a date.</small>

This initial reporting form (Tracking I) should be submitted within thirty (30) days following disposition to:

Department of Juvenile Justice - ATTN: Offender Information Administrator
1025 Capital Center Drive – 3rd Floor – Frankfort, KY 40601-8205

Part II of the Juvenile Sexual Offender Tracking Report will be completed by the Offender Information Administrator. The completed Tracking I & Tracking II forms will be returned to the JSW.

KRS 635.545 505 KAR 1:160

Juvenile Sexual Offender Tracking System

Reporting Form - Part II

Youth Information:

Last Name _____
First Name _____
DJJ# _____
Race _____
Sex _____
DOB: _____

Court _____
District _____

Post-Disposition Placement Data

Placement:	_____	Date:	_____
Placement:	_____	Date:	_____
Placement:	_____	Date:	_____
Placement:	_____	Date:	_____

Prior Legal History

- 1 Was youth ever placed on probation for a status offense? _____
- 2 Was youth ever placed on probation for a public offense? _____
- 3 Was youth ever committed as a status offender? _____
- 4 Was youth ever committed as a public offender? _____
- 5 Has youth previously been charged with a sex offense? _____

Victimization Histroy

- | | | | |
|---------------------------------------------------------------|-------|---------------------------------------|-------|
| 1 Was youth a victim of child neglect? | _____ | if yes, approximate age at occurrence | _____ |
| 2 Was youth a victim of physical abuse? | _____ | if yes, approximate age at occurrence | _____ |
| 3 Was youth a victim of sexual abuse? | _____ | if yes, approximate age at occurrence | _____ |
| 4 Was youth a victim of sexual assault excluding child abuse? | _____ | if yes, approximate age at occurrence | _____ |