SUPERIOR COURT OF CALIFORNIA

CITY AND COUNTY OF ALAMEDA

MARGARET FARRELL, Plaintiff, vs. MATTHEW CATE, Defendant.	)	CASE NO. RG03079344

TWELFTH REPORT OF SPECIAL MASTER

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APPENDICES

I. INTRODUCTION

This report reviews the 2009 report of the sexual behavior treatment expert and summarizes the status of compliance with the Sexual Behavior Treatment Program Remedial Plan. The sexual behavior treatment expert's report is included as Appendix A. The office of the special master (OSM) provided a draft of this report and the expert's report for the parties' comments. OSM and expert submit these final reports after consideration of the parties' comments.

II. SEXUAL BEHAVIOR TREATMENT

The *Farrell* sexual behavior treatment expert, Dr. Barbara Schwartz, conducted her fourth audit of DJJ's sexual behavior treatment program (SBTP) between January 2009 and June 2009.[1] Dr. Schwartz reviewed and approved this section of the special master's report.[2]

DJJ's capacity to develop a standardized SBTP improved notably as a result of changes at central office in late 2008 and early 2009. DJJ created a Court Compliance Task Force in December 2008 and devoted greater attention to increasing compliance with the SBTP remedial plan. Erin Peel, formerly of Chaderjian, began serving as Sex Behavior Treatment Team Leader in December.[3] Dr. Heather Bowlds, formerly at O.H.

[1] *See* Appendix A, Barbara Schwartz, California Department of Corrections: Division of Juvenile Justice Sex Behavior Treatment Program Audit 4, September 2009, p. 2 [hereinafter Barbara Schwartz, 2009 Audit Report]. Dr. Schwartz visited DJJ's central office and its four facilities with residential SBTP units: Chaderjian, O.H. Close, Stark, and SYCRCC. *See ibid.* Unlike last year, she did not visit the Preston facility because it has discontinued its outpatient SBTP. *See ibid.*; Eighth Report of the Special Master (February 2009), p. 12.

[2] *See* e-mail of Barbara Schwartz to Aubra Fletcher, November 3, 2009.

[3] *See* DJJ Quarterly Report (July 31, 2009), Org Chart 28, June 29, 2009; e-mail of Mike Brady to Donna Brorby, et al., December 24, 2008.

Close, became acting SBTP coordinator in January 2009.[4] Dr. Bowlds and Ms. Peel work closely together and maintain regular communication with Dr. Schwartz.

A. Program Policies and Guidelines

Dr. Bowlds oversaw the development of an SBTP program guide this year.[5] The program guide will function as a governing policy and encompasses most aspects of the SBTP, from initial assessment to reentry preparation.[6] Dr. Schwartz has approved the program guide's content,[7] and DJJ's SBTP Task Force has begun to develop a plan for the guide's implementation.[8] The guide makes possible an escalation of efforts to develop program curricula and paves the way for a standardized program of sexual behavior treatment across DJJ.

The program guide does not address treatment confidentiality or informed consent.[9] In August 2009 DJJ shared a draft treatment confidentiality policy with Dr. Schwartz and all other *Farrell* experts.[10] OSM and the experts provided written feedback in early September 2009 and are awaiting a response as of mid-December 2009.[11] DJJ has not begun drafting a policy addressing informed consent to sexual behavior

[4] *See* e-mail of Ed Morales to Donna Brorby, et al., December 12, 2008.
[5] *See* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009. Dr. Schwartz had identified the completion of the program guide as her first priority for fiscal year 2009-2010. *See* Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[6] *See generally* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009; *see also* Barbara Schwartz, 2009 Audit Report, p. 3.
[7] *See, e.g.*, statements of Barbara Schwartz during DJJ Court Compliance Task Force meeting, September 24, 2009.
[8] Statements of Heather Bowlds during DJJ Court Compliance Task Force meeting, September 24, 2009.
[9] The remedial plan requires DJJ to promulgate confidentiality and informed consent policies. *See* Sexual Behavior Treatment Remedial Plan, Standards and Criteria, item 14. Dr. Schwartz has identified the development of a treatment confidentiality and informed consent policy as a priority for fiscal years 2008-2009 and 2009-2010. *See* Ninth Report of the Special Master (June 2009), Appendix A (Experts' Priorities for Fiscal Year 2008-2009), p. 4; Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[10] *See* DJJ, Treatment Confidentiality (draft policy), August 10, 2009 (provided as PoP # 477, August 6, 2009).
[11] *See, e.g.*, e-mail of Aubra Fletcher to Thy Vuong, et al., September 2, 2009.

treatment. As the special master has previously noted, providing sexual behavior treatment to youth without appropriately documented informed consent raises immense ethical concerns.[12] Dr. Schwartz has raised this issue with DJJ management and counsel since her involvement with *Farrell* began.[13] She reiterates in her 2009 report that "DJJ's psychologists are placing their licenses in jeopardy every day that they continue to treat these youths without clarification of these issues."[14]

B. Curriculum

The program guide provides a context and foundation for the development of an SBTP curriculum.[15] Dr. Bowlds has begun writing the new residential program curriculum for males[16] and is working to secure outside assistance by contract.[17] DJJ expects a contractor to be in place by March 15, 2010.[18] DJJ has acknowledged the need for a separate curriculum for female youth with sexual behavior issues, and counsel for DJJ has informed the OSM that the curriculum-development contract will encompass the development of a curriculum for females.[19] As of June 2009, DJJ housed eight young women in need of sexual behavior treatment.[20]

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[12] *See* Eighth Report of the Special Master (February 2009), p. 20; *id.* at Appendix C (Schwartz report), pp. 6, 9.
[13] *See* Second Report of the Special Master (June 2006), p. 14; Fifth Report of the Special Master (October 2007), Appendix C (Schwartz 2006-2007 report), pp. 2, 11.
[14] *See* Barbara Schwartz, 2009 Audit Report, p. 7.
[15] Dr. Schwartz has identified curriculum development as a priority for fiscal years 2008-2009 and 2009-2010. *See* Ninth Report of the Special Master (June 2009), Appendix A (Experts' Priorities for Fiscal Year 2008-2009), p. 4; Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[16] *See, e.g.*, statements of Heather Bowlds during central office site visit, June 8, 2009; Barbara Schwartz, 2009 Audit Report, p. 8.
[17] Statements of Heather Bowlds during DJJ Court Compliance Task Force meeting, September 24, 2009. DJJ decided to seek a contractor to assist with curriculum writing after consultation with Dr. Schwartz, who endorses the decision to contract. *See, e.g.*, statements of Barbara Schwartz to Aubra Fletcher during teleconference, September 24, 2009; Barbara Schwartz, 2009 Audit Report, pp. 7-8.
[18] *See* memorandum of William Kwong to Donna Brorby, December 10, 2009, p. 1.
[19] *Ibid.*
[20] Memorandum of Barbara Mendenhall to Heather Bowlds, May 6, 2009, pp. 2-3.

The remedial plan requires DJJ's SBTP to incorporate a "healthy living" curriculum, which offers the first step in sexual behavior treatment for most youth, and the only step for some.[21] All facilities with an SBTP piloted a "healthy living" curriculum during 2008, with Dr. Schwartz's approval.[22] DJJ has not used the curriculum since the pilot;[23] a legal dispute with the contract curriculum writer reportedly prevented the curriculum's use until April 2009.[24] In May 2009, DJJ began revising the curriculum in response to the pilot.[25] Dr. Schwartz generally approved the curriculum in October 2009, though she offered recommendations for some improvements.[26]

C. Screening and Assessment

The SBTP remedial plan mandates appropriate screening and assessment tools to evaluate risk and treatment needs initially and on an ongoing basis.[27] Dr. Schwartz identified the implementation of a comprehensive assessment as a priority for fiscal year 2009-2010.[28] DJJ's new program guide outlines a screening and assessment protocol, which was approved by Dr. Schwartz but has not been implemented.[29] The program guide also creates a residential SBTP orientation unit, to be housed at Chaderjian, where

[21] *See* Sexual Behavior Treatment Program Remedial Plan, p. 14; Fifth Report of the Special Master (October 2007), p. 29 n.115.
[22] *See, e.g.*, Eighth Report of the Special Master (February 2009), Appendix C (Schwartz report), pp. 2, 5, 6, 8, 16, 21, 23, 27, 49, 53, 62, 81, 98, 114, 115; Barbara Schwartz, 2009 Audit Report, p. 8.
[23] The special master previously reported that DJJ continued to use the curriculum following the pilot, but this has since been clarified. *See* Eighth Report of the Special Master (February 2009), p. 13; e-mail of Heather Bowlds to Aubra Fletcher, October 13, 2009.
[24] E-mail of Heather Bowlds to Aubra Fletcher, October 13, 2009.
[25] *See* statements of Heather Bowlds during central office site visit, June 8, 2009; statements of Heather Bowlds during meeting with Barbara Schwartz and Aubra Fletcher, August 20, 2009; Barbara Schwartz, 2009 Audit Report, pp. 5, 8.
[26] *See* e-mail of Barbara Schwartz to Heather Bowlds, October 6, 2009.
[27] *See* Sexual Behavior Treatment Program Remedial Plan, Standards and Criteria, item 3.
[28] *See* Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[29] *See* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009, pp. 28-30.

much of the assessment and introduction to the SBTP will occur.[30] Dr. Schwartz has expressed strong support of the creation of an orientation unit.[31]

Though the implementation of DJJ's new protocol in its entirety will take time, there is no reason that DJJ cannot immediately begin to use the J-SOAP risk assessment tool that it agreed to use in March 2006 based on Dr. Schwartz's recommendation.[32] DJJ has implemented two other risk assessment tools under the 2008 mandate of the California legislature, beginning in January 2009. Because these tools are not validated for a population like DJJ's, DJJ has included the J-SOAP as a part of its assessment protocol.[33]

D. Organizational Structure

Dr. Schwartz has identified the production of "a meaningful organizational chart" as a priority for fiscal year 2009-2010.[34] The SBTP coordinator has historically lacked sufficient authority to hold SBTP staff accountable for adherence to program rules or completion of tasks.[35] DJJ's new program guide includes a chart depicting reporting relationships, but the SBTP coordinator still lacks the authority to hold clinical and non-

[30] *See id.*, pp. 16-23, 28-30; Barbara Schwartz, 2009 Audit Report, p. 4. The orientation unit will also serve as a "transition unit" for many outgoing youth. *See* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009, pp. 16-23, 28-30.
[31] *See, e.g.*, statements of Barbara Schwartz during central office site visit, June 8, 2009.
[32] *See* Second Report of the Special Master (June 2006), p. 15; Eighth Report of the Special Master (February 2009), p. 22.
[33] *See, e.g.*, Eighth Report of the Special Master (February 2009), p. 22. DJJ intends to use the J-SOAP alongside the non-validated instruments. Statements of Juan Carlos Arguello during Ventura site visit, December 3, 2008; Barbara Schwartz, 2009 Audit Report, p. 6. Dr. Bowlds explains that prior to her arrival not all staff had received J-SOAP training and that DJJ had not identified how exactly it would use the tool in conjunction with other assessments. The program guide Dr. Bowlds helped finalize describes how DJJ intends to use the J-SOAP; she expects the current SBTP units to use the tool together with the YASI to create treatment plans, and the tool will also form a part of the larger assessment that will take place on DJJ's future orientation unit. *See* e-mail of Heather Bowlds to Aubra Fletcher, et al., October 19, 2009.
[34] *See* Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[35] *See* Eighth Report of the Special Master (February 2009), pp. 16-17; Fifth Report of the Special Master (October 2007), p. 27.

clinical SBTP staff accountable.[36] The depicted structure at the facility level suffers the same problem: staff report along separate chains of command and operate within separate clinical and custody "silos."[37]

The sexual behavior treatment expert believes that a clear and adequate organizational structure is a prerequisite to the development and delivery of the sexual behavior treatment program.[38] She has raised this issue repeatedly in her reports and in contacts with DJJ management.[39] Without clarity as to actual reporting relationships, the SBTP coordinator cannot ensure the delivery of treatment services in an organized and consistent manner.

Dr. Schwartz reported again this year that staff do not follow a standardized treatment approach, which "leads to the type of inconsistency that has been a problem for this program in the past."[40] Psychologists apply varied approaches to treatment.[41] No facility consistently provides the required amount of treatment hours to youth.[42] The role of youth correctional counselors (YCCs) in therapy groups varies across the state.[43] Facilities offer differing levels of treatment to youth with co-morbid disorders or special

[36] *See* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009, p. 38; statements of Barbara Schwartz during teleconference, October 20, 2009.
[37] *See* Appendix B, DJJ, Sexual Behavior Treatment Program Guide, September 3, 2009, p. 38; statements of Barbara Schwartz during teleconference, October 20, 2009.
[38] Eighth Report of the Special Master (February 2009), p. 17.
[39] *Ibid.*; statements of Barbara Schwartz to OSM during meeting of OSM and experts, August 29, 2008; statements of Barbara Schwartz during teleconference, September 16, 2008; e-mail of Barbara Schwartz to Doug Ugarkovich, November 6, 2008; statements of Barbara Schwartz to OSM during teleconference, December 30, 2008.
[40] *See* Barbara Schwartz, *Farrell* SBTP Audit: H.G. Stark, July 24, 2009, p. 3.
[41] *See* Barbara Schwartz, 2009 Audit Report, pp. 9-12. Dr. Schwartz notes that the current model is incomplete. *See id.*, p. 9.
[42] *See id.*, p. 9. Dr. Schwartz found some improvement in the number of documented treatment hours provided to youth. *See ibid.*
[43] *Ibid.*

treatment.[44] The lack of clear lines of accountability at times results in open defiance of the current treatment model.[45]

E. Record Keeping

For the first time since Dr. Schwartz began auditing DJJ facilities, all sites were using the new version of the Ward Information Network (WIN) to track services provided to youth.[46] WIN is a helpful source of information,[47] but inconsistent, duplicative, and incomplete treatment-related recordkeeping continues to be a problem even in electronic form. For example, co-facilitators of a single group session take separate, often contradictory, notes and store them in different locations.[48] This practice persists despite Dr. Schwartz's past recommendations that it cease.[49] Also, a problem in the WIN system prevented it from consistently displaying treatment minutes logged by providers.[50] Thus, the time spent in individual or group sessions did not always appear on the case note entry describing the session. It is unknown to what extent this was due to the WIN glitch or to staff failure to log minutes.

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[44] *Id.*, p. 12.
[45] Dr. Schwartz encountered "staff who were openly defiant when discussing uniformity of treatment" during her last two site visits. *See id.*, p. 10. For example, "[o]ne YCC has told [Dr. Schwartz] that he has no intention of following a preset curriculum but gives his own version of Anger Management, including bastardizing Aggression Replacement Therapy, a copyrighted program." *Id.*, p. 6; *see also* Barbara Schwartz, *Farrell* SBTP Audit: H.G. Stark, July 24, 2009, p. 3.
[46] The new WIN was just coming on line as Dr. Schwartz completed her monitoring and reporting for fiscal year 2007-2008. Eighth Report of the Special Master (February 2009), p. 22.
[47] *See ibid.*
[48] *See* Barbara Schwartz, *Farrell* SBTP Audit: Chaderjian, July 1, 2009, p. 4; Barbara Schwartz, *Farrell* SBTP Audit: O.H. Close, June 30, 2009, p. 3; Barbara Schwartz, *Farrell* SBTP Audit: H.G. Stark, July 24, 2009, p. 2; Barbara Schwartz, *Farrell* SBTP Audit: SYCRCC, June 30, 2009, p. 4.
[49] *See* Eighth Report of the Special Master (February 2009), Appendix C (Schwartz report), pp. 11, 27, 32, 33, 34, 64, 85.
[50] *See* Barbara Schwartz, *Farrell* SBTP Audit: Chaderjian, July 1, 2009, p. 4; Barbara Schwartz, *Farrell* SBTP Audit: O.H. Close, June 30, 2009, p. 3; Barbara Schwartz, *Farrell* SBTP Audit: H.G. Stark, July 24, 2009, p. 2; Barbara Schwartz, *Farrell* SBTP Audit: SYCRCC, June 30, 2009, p. 5. The remainder of this paragraph is based on these sources.

DJJ is finalizing dramatic improvements to the SBTP-related WIN features and demonstrated the new system for Dr. Schwartz and monitor Aubra Fletcher in January 2009.[51] These features include automated tracking of residential placements, therapy and resource group assignments, and services provided. The "achievement matrix" document which DJJ began to use in 2008 will be automated. Appropriate security restrictions will prevent unauthorized staff from viewing youth clinical records. The SBTP coordinator will be able to view all SBTP youths' electronic records from Sacramento. As of the end of September 2009, DJJ planned to pilot the new WIN features at O.H. Close during the month of October.[52]

F. Other Areas of Improvement and Need

Areas of continued progress include the use of multidisciplinary teams to conduct quarterly treatment reviews at all facilities.[53] Some SBTP units have established youth committees to increase the role of youth in living unit activities and operations.[54] All facilities are involving youth in community service activities.[55] And in addition to completing the SBTP program guide, central office has begun drafting a revised SBTP remedial plan in consultation with Dr. Schwartz and OSM.[56]

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[51] WIN programmer Ed Chance and SBTP Team Leader Erin Peel presented a demonstration at DJJ's central office on January 30, 2009. Unless otherwise noted, the remainder of this paragraph is based on information provided during that presentation.
[52] Statements of Heather Bowlds during DJJ Court Compliance Task Force meeting, September 24, 2009.
[53] Barbara Schwartz, 2009 Audit Report, p. 17.
[54] *Id.*, p. 12.
[55] *Ibid.*
[56] *See, e.g.*, Sexual Behavior Treatment Program Remedial Plan draft, undated (provided as PoP #506, September 28, 2009); e-mail of Aubra Fletcher to Erin Peel, et al., September 29, 2009 (attaching response to draft plan from OSM, Dr. Schwartz, and Dr. Terry Lee); Barbara Schwartz, 2009 Audit Report, p. 5. Dr. Schwartz considers the revision of the remedial plan to be a priority for this fiscal year. *See* Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.

Staff training at DJJ has also improved this year. DJJ sent Dr. Bowlds to a national conference highly recommended by Dr. Schwartz in March 2009.[57] Dr. Bowlds has since provided day-long trainings at each facility with a residential SBTP.[58] DJJ also sent four SBTP staff to a California Coalition on Sexual Offending conference this spring.[59] Adjunct SBTP staff, however, are still in need of training.[60]

Dr. Schwartz raises concerns regarding various aspects of the delivery of treatment. Again this year, she found that psychologists are failing to provide the requisite hours of one-on-one treatment to youth.[61] Almost all facilities lacked adequate physical space for treatment as of the expert's site visits.[62] DJJ continues to staff its SBTP units with YCCs based on a shift-and-bid system that often results in inappropriate staff placements.[63] Once assigned to an SBTP unit, YCCs do not receive the training or supervision necessary to become qualified treatment providers.[64] Yet, DJJ directs its YCCs to teach psycho-educational resource groups, to co-facilitate therapy groups, and to provide individual "treatment" to youths.[65] DJJ also directs YCCs to develop treatment

[57] *See, e.g.*, e-mail of Erin Peel to Aubra Fletcher, March 23, 2009.
[58] Barbara Schwartz, 2009 Audit Report, pp. 5, 7.
[59] Statements of Erin Peel and Heather Bowlds during central office site visit, June 8, 2009.
[60] Barbara Schwartz, 2009 Audit Report, p. 8. Adjunct staff include educational, medical, recreational, and security staff who interact with SBTP youth. *See* Sexual Behavior Treatment Program Remedial Plan, Standards and Criteria, item 27.
[61] Barbara Schwartz, 2009 Audit Report, p. 10.
[62] *Id.*, p. 13. Improvements to physical space have occurred following the close of the expert's audit round. *See, e.g.*, memorandum of William Kwong to Donna Brorby, December 10, 2009, p. 2.
[63] Barbara Schwartz, 2009 Audit Report, p. 7; *see also* Barbara Schwartz, *Farrell* SBTP Audit: O.H. Close, June 30, 2009, pp. 1-2. Dr. Schwartz has called on DJJ to make the solution to this problem a priority. *See* Ninth Report of the Special Master (June 2009), Appendix A (Experts' Priorities for Fiscal Year 2008-2009), p. 4; Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.
[64] Barbara Schwartz, 2009 Audit Report, pp. 6-7 ("YCCs can be valuable treatment providers if they are selected for their ability to work with this population, provided with intensive ongoing training and supervision, provided with approved curriculum which they are mandated to rigorously follow and follow carefully developed and highly individualized treatment plans.").
[65] *See id.*, pp. 6-7, 9. Dr. Schwartz writes that DJJ documents case work provided by YCCs as if it were individual "treatment." *See id.*, p. 6. She adds: "Treatment is not casework. Treatment is provided by a

plans for individual youth,[66] rather than assigning this task to staff who possess the "fairly sophisticated skill" necessary for treatment plan development.[67] Dr. Schwartz recommends that treatment plans be highly individualized and specific as to interventions, timelines, and responsible staff, and that DJJ mandate YCCs to follow them rigorously.[68]

Dr. Schwartz finds that one facility's choices of "victim outreach" projects for SBTP youth were inappropriate. Staff at O.H. Close coordinated a project in which SBTP youth made Valentine's Day cards for abused children and women at local shelters in February 2009.[69] In March, staff directed youth to make blankets for the abused children.[70] Dr. Schwartz described these activities as "inappropriate[] . . . for this particular population" because they prompt sexually inappropriate youth to focus on children.[71] DJJ responded to the expert's determination that such activities were inappropriate for SBTP youth, and for the shelter residents, by asserting that "providing blankets for children is appropriate for this population due to many victims being children . . . . [O.H. Close's SBTP] provides a resource for children who face many of the same obstacles and stressors as our youth."[72] In her comprehensive report the expert

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qualified mental health professional. This does not necessarily mean a psychologist . . . . It does not mean a YCC unless that individual is also a qualified mental health professional." *See id.*, p. 10.

[66] Statements of Heather Bowlds during meeting with Barbara Schwartz and Aubra Fletcher, August 20, 2009.

[67] *See* Barbara Schwartz, 2009 Audit Report, p. 12 (also noting that treatment plans are often "vague, redundant, and reference[] interventions which were not available"). Additionally, at "several institutions youths were assigned to special resource groups" regardless of whether the youth was in need of the special group or not. *Id.*, p. 11.

[68] *See id.*, pp. 6, 12. Currently, staff allow youth to "languish at various stages [of treatment] without active intervention." *See id.*, p. 11.

[69] Barbara Schwartz, *Farrell* SBTP Audit: O.H. Close, June 30, 2009, p. 23.

[70] *Ibid.*; *see also* e-mail of William Kwong to Barbara Schwartz, et al., August 5, 2009 (attaching DJJ's comments on Dr. Schwartz's draft informal report for O.H. Close).

[71] *See* Barbara Schwartz, *Farrell* SBTP Audit: O.H. Close, June 30, 2009, pp. 12, 23.

[72] *See* e-mail of William Kwong to Barbara Schwartz, et al., August 5, 2009 (attaching DJJ's comments on Dr. Schwartz's draft informal report for O.H. Close).

reiterates that these activities were "clearly not appropriate" for a population that includes youth who have sexually abused children.[73]

III. CONCLUSION

OSM recommends that the Court consider modifying the SBTP Remedial Plan to assign a deadline for implementation of an adequate informed consent policy.[74] As discussed above, providing sexual behavior treatment without appropriately documenting youths' informed consent raises immense ethical concerns.[75] Dr. Schwartz and OSM have consistently raised this issue in reports and interactions with DJJ since 2005,[76] yet DJJ still has not begun drafting an informed consent policy.

The office of the special master respectfully submits this report.

Aubra Fletcher
Donna Brorby
Office of the Special Master

[73] *See* Barbara Schwartz, 2009 Audit Report, p. 12.
[74] *See* Consent Decree, ¶ 27(n) (special master may "[a]dvise the Court concerning any modification to the remedial plans that appears necessary to effectuate the Decree"); Sexual Behavior Treatment Remedial Plan, Standards and Criteria item 14 (requiring implementation of adequate informed consent policy, without assigning a deadline).
[75] *See*, *supra*, pp. 2-3.
[76] *See, e.g.*, Appendix A, Barbara Schwartz, 2009 Audit Report, p. 7; Second Report of the Special Master (June 2006), p. 14, Appendix D (Schwartz 2005 report), p. 2; Fifth Report of the Special Master (October 2007), pp. 28-29, Appendix C (Schwartz 2006-2007 report), pp. 2, 11; Eighth Report of the Special Master (February 2009), p. 20, Appendix C (Schwartz report), pp. 6, 9; Ninth Report of the Special Master (June 2009), Appendix A (Experts' Priorities for Fiscal Year 2008-2009), p. 4; Eleventh Report of the Special Master (November 2009), Appendix I (Experts' Priorities for Fiscal Year 2009-2010), p. 4.

California Department of Corrections: Division of Juvenile Justice
Sex Behavior Treatment Program

Audit 4
September 2009

Prepared by
Barbara Schwartz Ph.D.

The *Farrell* sexual behavior treatment expert, Dr. Barbara Schwartz, completed her fourth round of compliance audits in June 2009. The third audit round concluded in May 2008, the second in July 2007, and the first in late 2005. DJJ's central office and the four DJJ institutions with residential sexual behavior treatment units were audited in all four rounds: O.H. Close, Chaderjian, H.G. Stark, and Southern. During the third audit round, the expert visited the outpatient SBTP at Preston; this program was discontinued prior to the beginning of the fourth round.

The expert audited each site for compliance with the specific items noted in the Remedial Plan using the plan's Standards and Criteria audit tool. A detailed informal report was prepared for each site and shared with the Office of the Special Master, plaintiff's counsel, and DJJ. Each informal report contained compliance ratings and specific written comments. The informal report ratings were limited to non-compliance, partial compliance, and substantial compliance. In August 2009, DJJ requested that the expert begin using a fourth rating, "beginning compliance," based on the ratings scale in the mental health and safety and welfare standards and criteria. The expert has agreed, and the ratings definitions are as follows:

> **Substantial Compliance:** Practices follow policy with rare exception and exceptions lead to corrective action; trained staff fill all positions and vacancies are filled within 3 months; contractor has completed work in an acceptable manner; system is operational and audited and audit exceptions lead to corrective action; outcomes met or exceed performance targets.
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> **Partial Compliance:** Policy is implemented at some, but not all, locations or times; staff are hired but not trained; contractor is working but product not complete; system implemented at some, but not all, locations or times; outcomes meet or exceed performance targets some of the time.
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> **Beginning Compliance:** Policy is written and approved but not implemented; funding and hiring authority are approved but position not filled; training materials prepared and approved but training not started; RFP issued but contract not signed; system designed and approved but not implemented; outcomes being consistently measured.
>
> **Non-compliance:** No action taken and immediate steps needed to maintain schedule or prevent further delay.

This report begins with a report on compliance with the Remedial Plan at the central office level. A summary of findings at the various facilities follows, and the report concludes with a table depicting the compliance ratings assigned by the expert.

I. Farrell SBTP Audit: Central Office

Date of visit: June 8, 2009
Audit conducted by Barbara Schwartz, Ph.D.

Present: Heather Bowlds, Erin Peel, William Kwong, Mike Brady, Barbara Schwartz, Aubra Fletcher.

SBTP Program Coordinator:

Since my last report, former SBTP coordinator Fred Martin has left DJJ. Dr. Heather Bowlds has served as acting SBTP coordinator since January 2009.

Policies and Procedures:

DJJ has chosen to develop an SBTP "program guide" rather than a "policy," to allow for greater flexibility should changes to the program become appropriate in the future. I have approved of this decision, with the understanding that a program guide will be no less binding on personnel than a policy would be.

To develop the SBTP program guide, DJJ is utilizing its new project management process, which seems to entail a great deal of time spent in meetings, and I am concerned at the involvement of committees where the work of fewer, more directly qualified people would be more efficient and appropriate.

The project management process begins with a "project charter," which describes the task to be completed and the resources needed. The SBTP charter includes the development of both a program guide and the new SBTP curriculum. Staff began writing the SBTP charter in late February 2009, and as of September 2009, the program guide had been finalized, with the expert's approval. DJJ's next task is to write the curriculum, and it is seeking the assistance of an outside contractor.

Dr. Bowlds explained that DJJ is developing a Parole Board Resource Guide to help the board understand risk assessment. Training was to occur on June 24, 2009. They will also be invited to participate in SBTP trainings. Reportedly, they are enthusiastic about the training. In the past, the board has treated youths' completion of the SBTP as a "program failure" and has penalized youth for it. This should have been addressed sooner, but it is hoped that the June 24 training will eliminate this problem.

Screening and Assessment:

It was reported that of new admissions evaluated and referred to SBTP since January 2009, 60% have gone to facilities in the North and 40% to facilities in the South. This will likely change with the planned closure of the Stark facility, though DJJ will add an SBTP unit at Southern.

SBTP staff are developing an assessment battery, which could include the following:

- The Trauma Symptoms Inventory
- A measure of auditory processing
- A clinical interview and the YASI, which would assess family issues
- J-SOAP, which would be connected to the YASI and done periodically
- The MAYSI as a personality inventory
- The MIDSA (the use of which might be limited by budgetary reasons)
- Neuropsychological screening

Based on outcomes, a clinician will create an individual treatment plan and determine the appropriate residential/programmatic placement for the youth.

Treatment Model:

There was a good deal of discussion about how Dr. Bowlds would like the treatment model to incorporate an Orientation Unit. This would be a residential unit (site unknown) that would provide SBTP with a place to do intensive assessments and develop sophisticated treatment plans. Youth would receive the Healthy Living curriculum, and the unit would provide a place to motivate those youth who are still in the pre-contemplative phase of change and offer young persons who have cases on appeal some exposure to treatment that deals with related domains without dealing directly with guilt or innocence. While it is conceptualized as a short-term placement, it could be extended if appropriate for a specific youth.

Dr. Bowlds also discussed the intention to provide "outpatient" therapy to youth in need of treatment for sexually inappropriate behavior but who are in need of mental health placement, are developmentally disabled or are parole violators.

These concepts have not been written into any of the SBTP plans that I have been subsequently provided with.

Staff Qualifications:

Staff qualifications were reviewed. There are some job classifications which require MSWs or significant work towards this degree, such as Casework Specialist or Supervising Caseworker. Some of these classifications could be used to deliver direct treatment for the SBTP instead of focusing on psychologists.

DJJ is currently surveying its SBTP staff in order to provide the expert with additional information.

Staff Training:

Dr. Bowlds has been delivering training to the various treatment sites. She provided four hours of treatment and the teams then met for 4 hours. The staff has also been trained in classes entitled "Cognitive Behavioral Primer," "Motivational Interviewing (a three day training)," "Group Facilitating," and "Preventing Suicide." Dr. Bowlds has trained 14 staff at Chad, 19 at Close, 17 at Southern and 8 at Stark.

Additionally, Dr. Bowlds has been developing a contracting system for dealing with specific behavioral and treatment problems. She is also planning on doing further training with the M-2 (religious) volunteers and the Parole Board.

DJJ plans to complete a staff qualifications survey and will provide me with the resulting data.

Program Evaluation:

There was an evaluation proposal for SBTP. However, the person who was to coordinate this has been laid off, and Barbara Mendelhall, who has been doing the research for the program, is being laid off. Her position has been filled by another researcher.

Healthy Living:

A group which is supposed to be revising the Healthy Living curriculum is reportedly working with a curriculum developer. More experiential exercises are being added. I certainly approve of the latter but have not yet reviewed the entire re-write. A good deal of thought and research went into the format of the curriculum, and this should be preserved.

Remedial Plan:

DJJ is working with the expert and the special master's office to draft a revised remedial plan. Erin Peel presented her proposed Remedial Plan during a meeting in June. Much of the discussion focused on the new approach to individualizing treatment. Rather than mandating that every youth be given the same exact treatment, the therapy would be responsive to individual needs. It was agreed that instead of mandating that youth receive a specific amount of core group, individual treatment, resource group, etc, the consensus was that a youth would not receive fewer than a certain number of hours of treatment. I talked with Mike Brady and indicated that I agreed with that direction. I have provided comments on a more recent draft of this document.

Female Youth:

According to Dr. Bowlds, it appears that will not be able to find a single contractor for all women's programming, as it had hoped. A specific SBTP for young women is needed. DJJ must either seek a contract or develop a program for females itself. There are contractors in the community that would be interested in providing this service if compensated at a reasonable rate.

Issues

Standard 1: Policies and Procedures—A few policies have been supplied to me, such as the WIC 1800 policy, though it is not exclusively aimed at SBTP participants. However, no policies have been finalized that specifically address this program. DJJ intends the Program Guide to serve as the policies and procedures. Regardless of the format, the development of all the specifics dealing with this program must await the development and the endorsement of the SBTP Program Guide.

Standards 3.1 and 2: Screening and Assessment—It is my understanding that the J-SORRAT and the STATIC-99 have been adapted and in use since January 2009. I shall await information about how exactly the results are being utilized before commenting on the use of these instruments. A variety of instruments have been proposed as an initial assessment. However, the battery is designed to be delivered in an Orientation Unit. I am not aware that this idea has been formally proposed to the DJJ administration. Issues of location, staffing or funding may remain to be determined. Certainly it was not referenced in the proposed remedial plan. Until these details are resolved, the list of instruments is tangential to the overall issue.

Standard 10: Staff Qualifications—The issue here is less about whether qualified individuals are filling various job categories than whether job duties are being assigned to the various job categories. For example, YCCs are assigned to teach resource groups. A YCC can have either an undergraduate degree in anything, one year as a peace officer or two years of working with youth plus sixty college hours. This latter qualification could be met by studying any combination of college courses and having worked for two years as a YCO. This would not qualify YCCs to develop curriculums on which the resource groups are based. One YCC has told me that he has no intention of following a preset curriculum but gives his own version of Anger Management, including bastardizing Aggression Replacement Therapy, a copyrighted program. While YCCs are instructed to teach these classes on their own, they rarely lead the core groups when the psychologist is absent.

Additionally, casework provided by YCCs is presented as individual treatment. YCCs can be valuable treatment providers if they are selected for their ability to work with this population, provided with intensive ongoing training and supervision, provided with approved curriculum which they are mandated to rigorously follow and follow carefully developed and highly individualized treatment plans.

This brings up the issue of the bid system, which often results in YCCs who do not want to work with this population — and who may even be traumatized by having to work with this issue — being assigned to these units. This system also removes highly trained and devoted YCCs from these programs.

Compliance with this standard will await the development of approved curriculums for every resource group, the overall SBTP curriculum, intensive training for all staff assigned to the SBTP, as well as exemption of the SBTP units from the post and bid system.

Standard 11: Staff Training—Staff training has improved since Dr. Bowlds took over the coordinator's position. This standard involves intensive orientation training and ongoing training of the staff who will develop the new treatment model, which is largely based on the development of the curriculum. DJJ is continuing to support staff attendance of regional conferences. This standard will be met when the curriculums and program guide are adopted.

Standard 14: Ethics—I am awaiting a policy that specifically addresses issues of confidentiality and informed consent as they pertain to the youth in the SBTP. Because California uses civil commitment, these issues are much more sensitive for SBTP youth than for the rest of the DJJ population. DJJ records can be used in civil commitment trials. Given the extreme possible consequences of having SBTP records turned over to district attorneys in these procedures, it is questionable whether underage individuals are competent to give this kind of consent. Only when these highly complicated issues are addressed can the appropriate forms be developed.

This was the first issue I raised when I began in my DJJ position and it remains unaddressed. Because these are core ethical issues, I feel that DJJ's psychologists are placing their licenses in jeopardy every day that they continue to treat these youths without clarification of these issues.

To date, I have only been provided with a draft treatment confidentiality policy. As I stated in my comments to DJJ regarding the policy, it does not adequately address the issues I have identified above.

Standard 19: Program Evaluation—I have been told that a program evaluation has been developed, although the staff needed to implement it have been laid off. I have not had the chance to give feedback on the evaluation proposal. Part of this standard could be completed if I could review this proposal.

Standard 20: Program Materials—This standard originally contemplated the retention of an outside group or consultant to prepare this curriculum. When the contract with Dr. Cellini was not renewed, the project was turned over to the DJJ staff. Dr. Cellini has partially completed the curriculum. There is now a work group

reportedly developing the crucial curriculum, as well as efforts to secure an outside contract. However, other than an introduction and a draft of an outline of an autobiography, I have seen no evidence that any other parts have been written. I am becoming increasingly skeptical that a group of individuals who have little to no experience writing a curriculum can accomplish this task.

Standard 26: Healthy Sexuality—I initially reviewed and enthusiastically approved of the first draft of the Healthy Living curriculum that was to be piloted at several institutions. Some recommendations were sent back to former contractor, Dr. Cellini, although the curriculum was not consistently piloted in the way it was designed (some facilities did not use the overheads that were a critical part of the curriculum). Before he could finish responding to the recommendations, his contract was not renewed. The curriculum is now being rewritten.

Standard 27: Training of Adjunct Staff—There has been some training of adjunct staff in various institutions, but this was not part of an approved training curriculum on sexually inappropriate youth. Since this staff primarily needs a very basic overview of relevant issues, Dr. Bowlds could be developing this currently.

II. Facilities: Summary of Institutional Standards

The following is a summary of the finding on the standards applicable to the four institutions that were reviewed. The expert visited Chaderjian on March 9, 2009, O.H. Close on March 10, 2009, Stark on April 20-21, 2009, and Southern on May 7, 2009.

Standard 2-1 Treatment Model

This standard is redundant of Standard 4-4 and to some extent with Standard 7 in terms of providing for individualized treatment and the provision of special resource groups and other individualized treatments.

Standard 4-1 Multi-model Treatment Model –Core Treatment

The SBTP model requires three hours per week of core group treatment. This is the basic treatment group dealing with issues related to sexually inappropriate behavior such as basic admission of the behavior, autobiography, clarification letters, thinking errors, cycle work, and relapse prevention. This group uses a cognitive behavioral approach. It is to be offered by a psychologist with a YCC as co-therapist. There should be no less than four residents in the group and no more than ten. The group should be offered in two sessions per week of 90 minute duration. Discussion should be mixed with experiential exercises.

While some of the YCC's that serve as co-therapists were very knowledgeable and, in fact, the best group that I observed in this round of audits was conducted by a newly hired YCC and a Senior YCC, other YCC's did not join in the group and simply took notes. During this audit period psychologists were frequently absent due to training, meetings or other assignments and YCC's rarely conducted the full group. The groups were either cancelled or limited to check-ins.

The SBTP does not have a consistent treatment model which is uniformly followed. Some psychologists are following the old model that is incomplete. Others have devised their own versions.

Although there has been some improvement in the amount of hours provided, no institution consistently provided the required amount. This is a reflection of a lack of leadership, which is related to organizational confusion. The unit director and the senior psychologist are supposed to coordinate the provision of treatment. However, who is responsible for the failure to provide the required hours of core therapy? Is the failure of the YCC's to conduct an acceptable core group the fault of the senior psychologists for not ensuring that the psychologists are not called away from the groups or the fault of the unit for not ensuring that the YCC's are adequately trained and comfortable offering these groups? Or is the fault of higher

up administration for not spotting the problem and insisting that the SBTP team provides the required amount of treatment?

The quantity of treatment should be a fairly easy requirement to comply with. The quality is a much more complex issue. The provision of an adequate treatment model including appropriate curriculums should provide uniformity. However, it will still be an administrative challenge to ensure that it is administrated in the required manner.

Standard 4-2: Multi-model Treatment Model-Individual Treatment

For years I have been reporting that psychologists are failing to provide the required number of hours of individual treatment. This has not changed.

The new program model will not require that every youth receive an hour a week of individual treatment. The provision of individual treatment will be individualized based on the needs of each ward. However, this might actually require that treatment providers spend more hours overall providing individual treatment.

The remedial plan states very specifically that the youths are to receive "individual treatment." Treatment is not casework. Treatment is provided by a qualified mental health professional. This does not necessarily mean a psychologist. This could certainly mean a counselor or a social worker or any other mental health professional. It does not mean a YCC unless that individual is also a qualified mental health professional.

Treatment, by definition, also must be provided following a written treatment plan, also devised by a qualified mental health professional.

Standard 4-3: Multi-model Treatment Model-Resource Groups

Resource groups are psycho-educational classes, which focus on a specific aspect of the treatment of sexually inappropriate youth. For example, a resource group could focus on social skills, anger management, victim empathy, or relapse prevention. Eight resource groups are to be offered at any particular time. These classes are to be offered by YCC's or other staff. They are to be based on an established curriculum. They are not to be an unstructured group as I found at some institutions. Other institutions are offering appropriate resource groups.

During the last two sets of visits I encountered staff who were openly defiant when discussing uniformity of treatment, including basing resource groups on evidence-based models where possible. It is extremely important that copyrighted curriculum such as Aggression Replacement Training be offered exactly as the DJJ staff has been trained to present it.

Standard 4-4: Multi-model Treatment Model-Special Resource Groups

Special resource groups are designed to respond to subgroups of youth who may have special needs. They could either be special core groups such as a core group conducted in Spanish or a core group designed for lower functioning individuals. Special resource groups can also be psycho-educational classes targeting special issues not shared by all of the youth in the SBTP. For example, a group might be designed for youths who have been victims of sexual abuse or youths who have a substance abuse problems. These groups must be based upon the needs of the youth as identified prior to the beginning of the groups (E.g. Every twelve weeks). At several institutions youths were assigned to special resource groups whether they had that particular problem or not.

Standard 4-5 and 4-6: Multi-model Treatment Model-Family Therapy

This standard refers to provision of family therapy, usually at particular stages. However, it was never intended to restrict family therapy to only these stages. On the whole the institutions were attempting to reach out to families. However, in some cases this simply consisted of offering a youth a phone call to his family. There needs to be careful documentation of the staff's efforts to involve the family in the youth's treatment.

Standard 4-7: Multi-model Treatment Model-Maintenance Groups

This standard refers to groups for youth who have finished the SBTP. The lack of such groups reflects the program's problem with helping youth progress through the program in a timely fashion. Most youths are maintained on the SBTP units until they are released from the institution. Often they do not finish the program. DJJ may decide that it is therapeutic to maintain participants who actually complete the stages on the units to act as peer counselors who also participate in maintenance groups. Alternatively DJJ might decide to transfer youth who have completed the program to general population and provide maintenance groups on an "outpatient" basis. Either way the aim should be that participants progress through the program to completion and not allowed to languish at various stages without active intervention.

Standard 6-1 and 6-2: Milieu Therapy

The SBTP is offered in a therapeutic community (TC) setting. TC's must encourage the formation of a meaningful community, which requires that not only must all of the community members including staff meet on a regular basis but also that youth in the program participate in the running of the community.

All of the institutions offered large groups but the time varied from 20 minutes to three hours. Furthermore the content of the groups was not always recorded. This could be

done by having youth rotate the job of scribe and record the minutes of the large group into a log which is kept on the unit.

The other component of this standard is participation of all youth in some aspect of running the unit. This is usually done by having committees on such issues as maintenance of the unit, holiday planning, birthdays, charitable activities, etc. Some units had established these committees while others had not.

Standard 7-1 and 7-2: Individuation of Treatment

This standard is somewhat redundant with Standard 2-1. It focuses on dealing with co-morbid disorders or special needs of individual SBTP participants. This could be addressed through individual treatment or through special resource groups. Additionally, this is provided when a youth is referred to a psychiatrist. This is being done to varying degrees in the institutions but it is not always clearly documented. For example, the treatment matrix provides a space to document referral to treatment for co-morbid disorders but this is not being completed.

Standard 8-1 and 8-2: Treatment Plans

Although case conferences are held periodically at all institutions, the plans do not reflect expertise in devising treatment plans, which is a fairly sophisticated skill. Treatment plans need to be very specific and objective. They need to reflect very specific interventions with time lines and the individuals responsible for implementing these interventions in a timely manner. Too often the treatment plans that I reviewed were vague, redundant, and referenced interventions which were not available.

Standard 9: Victim Contacts

All of the institutions were involved in various activities benefitting the community. However, some activities were clearly not appropriate for youth who have sexually abused children. This standard could have been met had copies of correspondence been provided on many of the activities.

Standard 12: Staff Supervision

While case reviews were provided for most units, records of the supervision of individual staff members were not available. If DJJ has a plan for supervisors to meet with staff to evaluate their performance, I would be able to evaluate this standard more accurately.

Standard 15: Program Completion

See comments under Standard 4-7.

Standard 23: Physical Facilities and Resources

At the time of the audit only one of the facilities had adequate physical space. The three others were either using temporary spaces such as an auditorium and a library or using space that did not ensure confidentiality. Since the visits, several institutions have reportedly corrected this problem.

Staff complained that space was not available for individual treatment. DJJ has responded that various rooms such as the offices of other staff members could be borrowed. However, this issue remains a problem.

III. 2009 Compliance Ratings

Audit #	Audit Description/Criteria	Audit Item	Central Office	Chad.	O.H. Close	Stark	SYCRCC
1	Written and officially approved policies and procedures will be included in a Program Manual that describes in detail the implementation of the SBTP	The expert will review the Program Manual and all policies and procedures to insure adequacy	BC				
2.1	Specific treatment programs are established to address a variety of special needs of youths with sexual behavior. Groups scheduled to be held are held with the exception of security cancellations. The expert will attend at least two groups at each facility during each period and the expert will interview administration, staff and participants at each facility during each audit period.	The expert will review group notes that document the existence of therapy groups directed at different risk levels and special need participants.		SC	PC	SC	PC
2.2		The expert will attend at least two groups at each facility during each audit period.					
2.3		The expert will interview administration, staff and participants at each facility during each audit period.					
3.1	Appropriate screening and assessment tools are used to evaluate risk and treatment need initially and on an ongoing basis. Included in the assessment protocol will be a evaluation of a participant's substance abuse history. These screening and assessment tools have demonstrated reliability and validity.	The expert will review the instruments and protocol for the development and/or selection and administration of appropriate screening and assessment tools.	PC				
3.2		The expert will access 10% of the records of program participants who have been in the program for three months and review for the presence of assessments that follow the established protocol.		NR	NA	NR	NR

4.1	The treatment program provides a multi-modal, multi-disciplinary and offense - specific model which is responsive to the evolving research on treatment efficacy in the field of treating youths with sexual behavior. The residential program will be presented at OH Close YCF, NA Chaderjian YCF, Southern Youth Correctional Center Clinic, Heman G. Stark YCF.	The expert will review 10% of files for the presence and appropriateness of group notes documenting individual progress in at least three hours of core group therapy per week.		**PC**	**PC**	**PC**	**PC**
4.2		The expert will review 10% of individual treatment notes documenting that each program participant receives individual work including Case Conferences and individuals sessions with treatment staff for at least three hours a week.		**PC**	**PC**	**PC**	**PC**
4.3		The expert will review for presence and appropriateness the resource group notes documenting that at least eight difference groups are offered on a 10-week schedule. The expert will review resource group schedule and lists of participants.		**PC**	**PC**	**PC**	**PC**
4.4		The expert will review 10% records for the presence and appropriateness of special resource group notes documenting that at least two different special resource groups offered on a 10-week schedule.		**PC**	**PC**	**SC**	**PC**
4.5		The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.		**PC**	**SC**	**PC**	**PC**
4.6		The expert will review for presence and appropriate-ness relevant documentation of meetings with family members.		**SC**	**SC**	**PC**	**PC**
4.7		The expert will review 10% of records for presence and appropriate-ness of group notes on maintenance groups for all program participants having completed Stage 10 documenting at least one hour of treatment a week following completion of residential treatment.		**PC**	**NA**	**NC**	**NA**
5.1	The treatment program provides a multi-modal, multi-disciplinary and offense-specific model which is responsive to the evolving research on	The expert will review 10% of records for presence and adequacy of group notes documenting individual progress in at least two hours of group therapy per week.		**NA**	**NA**	**NA**	**NA**

5.2	treatment efficacy in the field of treating youths with sexual behavior. This program will be provided at all facilities to medium risk youths with sexual behavior.	The expert will review 10% of records for the presence and adequacy of individual treatment notes documenting that each ward receives individual work including Case Conference and individuals sessions with treatment staff for at least one hour every 2 weeks		**NA**	**NA**	**NA**	**NA**
5.3		The expert will review 10 % of records for resource group notes documenting that at least one resource group is offered on a ten-week schedule.		**NA**	**NA**	**NA**	**NA**
5.4		The expert will review documentation reflecting an effort to involve relevant family members in the treatment program in Stages Three, Six and Nine.		**NA**	**NA**	**NA**	**NA**
5.5		The expert will review for presence and appropriate-ness relevant documentation of meetings with family members		**NA**	**NA**	**NA**	**NA**
5.6		The expert will review 10% of files for the presence and adequacy of group notes from maintenance groups conducted for all wards having completed Stage 10.		**NA**	**NA**	**NA**	**NA**
6.1	The SBTP residential component will be offered in a modified therapeutic community/milieu therapy model in which youths are provided with opportunities to learn appropriate social behaviors and are encouraged to exercise responsibility for themselves and others. The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.	The expert will review for presence and adequacy the notes of residential large group minutes documenting that such two groups are held per week for a total of four hours per week.		**PC**	**PC**	**PC**	**PC**
6.2		The expert will review committee and large group notes to ascertain whether program participants are participating in a variety of committees related to the operation of the residential treatment program.		**PC**	**SC**	**NC**	**NC**
6.3		The expert will attend large group meetings and meet with administration, staff and TC participants during each audit period to ascertain the functioning of the TC.					

7.1	The treatment of program participants with problematic sexual behavior is individualized through the provision of specialized groups and referral for ancillary therapeutic experiences.	Expert will review a random selection of 10% of records of program participants who have been identified with special needs and evaluate documentation that specialized services have been provided.		**SC**	**PC**	**PC**	**PC**
7.2		Expert will review rosters of specialized resource groups and other therapeutic experiences.		**SC**	**PC**	**PC**	**PC**
8.1	All program participants will have written treatment plans that are revised quarterly with clearly stated objective goals.	Expert will review a 10% of records for documentation of objective behavioral goals that are prepared and updated quarterly for all participants.		**PC**	**PC**	**PC**	**PC**
8.2		Expert will review those same clinical records for evidence that appropriate therapeutic interventions have been provided to assist the youth in meeting the behavioral goals.		**PC**	**PC**	**PC**	**PC**
9.1	The treatment program coordinates with treatment programs and therapists of individual victims as well as agencies that address sexual abuse in the community to combat the problem of sexual assault.	The expert will review the file of correspondence with community therapists.		**SC**	**SC**	**PC**	**SC**
9.2		The expert will review documentation of outreach to victims' agencies.		**SC**	**PC**	**PC**	**SC**
10	The program employs staff who are qualified and competent to work with youth with sexual behavior in a sufficient number to insure adequate treatment and supervision as well as a diversity of relevant skills.	Expert will review the number and professional qualifications of SBTP staff.	**PC**				

11	Staff is provided with relevant initial orientation and ongoing in-service training as outlined in the program plan as well as opportunities to attend professional conferences.	Expert will review training records of the SBTP staff.	**PC**				
12	The program provides regularly scheduled supervision for all staff working directly with wards.	The expert will review a log of supervision meetings.		**PC**	**SC**	**PC**	**NC**
13	The program uses multidisciplinary teams which conduct quarterly treatment reviews regarding client information	The expert will review minutes of the multi-disciplinary teams.		**SC**	**SC**	**SC**	**SC**
14.1	The program insures that treatment is offered in a way that respects the ethical principles of the involved professions as well as insuring that confidentiality, informed consent and due process are insured. All participants are informed and sign documents reflecting an understanding of the limits of confidentiality, informed consent to treatment and their due process rights.	The expert will review written procedures regarding confidentiality and informed consent.	**NC**				
14.2		Audit will review 10% of randomly selected files for documents signed by program participants informing them of these policies.	**NC**	**NR**	**NR**	**NR**	**NR**
15	Completion of the program reflects the completion of competency-based goals.	The expert will review 10% of clinical files of program completers for evidence that program completion was based on the completion of competency-based goals.		**NR**	**NR**	**NR**	**NR**

16.1	Suspension or termination for the SBTP are based on written policies which prescribe that the reasons for such measures are clearly documented, that staff undertakes proactive intervention when program completion is at jeopardy and that the principles of due process including impartial hearings and an appeal procedure are in place. The expert will review the written policy on suspension and termination to ensure that they are adequate.	The expert will review 10 % of clinical records for documents reflecting program participants' understanding of program rules related to suspension and termination.		**NA**	**PC**	**NR**	**NA**
16.2		Audit will review 20% of records of terminated or suspended participants to insure they comply with policy.		**NA**	**NR**	**NA**	**NA**
16.3		The expert will review the written policy on suspension and termination to ensure that they are adequate.	**NC**				
17.1	The pre-release process will be implemented 60 days before discharge and will include evaluation of proposed residence as well as the preparation of a pre-release package. Efforts will be made by the SBTP to help the program participants develop an appropriate support group, containment group or relapse prevention group.	The expert will review 20% of files of program participants who have completed the pre-release program for documentation that the program participants proposed residence has been evaluated and that the pre-release package was complete at the time of release.		**PC**	**SC**	**PC**	**SC**
17.2		The expert will review 10% of records of program participants who have completed the pre-release process for documentation (phone logs, records, etc) that efforts have been made to assist the program participant in acquiring an appropriate support group.		**PC**	**SC**	**PC**	**SC**
18.1	All CYA parole offices will provide aftercare treatment. Additionally efforts will be made to develop parole as an extension of treatment and informed supervision.	The expert will review monthly reports from community vendors to insure that they are in compliance with provisions of the contract.	**NR**				
18.2		The expert will review documentation that the SBTP has been involved in the training of parole personnel	**NR**				
19.1	CYA will conduct an evaluation of the SBTP which will assess basic demographic factors, progress in	The expert will review written proposal for the evaluation project and compliance with agreed upon deadlines.	**PC**				

19.2	treatment and treatment outcome including recidivism rates and their possible correlation with the above. If possible, a control group shall be identified and followed with the same variables. The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	The expert will review the evaluation itself to ensure that it is an accurate, reliable and valid reflection of the program.	**NC**				
20.1	CYA will seek a publisher to produce a standardized set of workbooks/journals for the SBTP to include specialized materials for developmentally disabled, females and Spanish-speakers. These materials will be culturally sensitive. The expert will review all prepared materials to ensure that they are appropriate.	Audit will review written contract with publisher for compliance with contract.	**PC**				
20.2		The expert will review all prepared materials to ensure that they are appropriate.	**PC**				
21	CYA will retain a full time program coordinator of the SBTP who will orchestrate the establishment and ongoing operation of all facets of the SBTP.	The expert will evaluate whether this position has been filled.	**SC**				
22	The CYA will make vocational opportunities available for youths with sexual behavior.	The expert will evaluated vocational training opportunities for youth with sexual behavior.		**SC**	**SC**	**SC**	**SC**
23	CYA will insure that adequate and appropriate physical facilities and resources including files, computers, printers, material s for experiential therapy, etc are available for both the residential and outpatient programs.	The expert will inspect the physical facilities and resources to insure that they are appropriate for conducting a therapeutic program.		**PC**	**PC**	**SC**	**NC**

24.1	SBTP will develop a behavioral management system based upon the latest research on effective approaches which will reward pro-social behavior and provide reasonable consequences for antisocial behaviors. The expert will review the behavioral management plan itself to insure that it is appropriate.	The expert will review 10% of all records for documentation which supports the use of such a system.		**SC**	**SC**	**SC**	**SC**
24.2		The expert will review 10% of files containing disciplinary reports for documentation which supports use of such a system.		**SC**	**SC**	**SC**	**SC**
24.3		The expert will review the behavioral management plan itself to ensure that it is appropriate.	**SC**	**SC**	**SC**	**SC**	**SC**
25.1	CYA will establish Healthy Sexuality Programs for all sex offender wards of CYA. The expert will review the Healthy Sexuality curriculum to insure that it is adequate.	The expert will review records which document existence of such programs.	**PC**	**NA**	**NA**	**NA**	**NA**
25.2		The expert will review the Healthy Sexuality curriculum to ensure that it is adequate.	**NR**				
26.1	SBTP staff will provide training to educational, medical, recreational and security staffs on the needs of youths with sexual behavior treatment concerns.	The expert will review training records documenting that adjunct staff of CYA facilities have been trained in the needs of youths with sexual behavior.	**NC**				
26.2		The expert will review the content of training materials to insure that quality training is being provided is suitable.	**NC**				

PERCENTAGE OF RATED ITEMS	**SC: 13%**	**SC: 44%**	**SC: 48%**	**SC: 32%**	**SC: 38%**
	PC: 44%	**PC: 56%**	**PC: 52%**	**PC: 60%**	**PC: 50%**
	BC: 6%	**BC: 0%**	**BC: 0%**	**BC: 0%**	**BC: 0%**
	NC: 38%	**NC: 0%**	**NC: 0%**	**NC: 8%**	**NC: 13%**
PERCENTAGE OF ALL RATABLE ITEMS	**SC: 11%**	**SC: 30%**	**SC: 32%**	**SC: 22%**	**SC: 24%**
	PC: 37%	**PC: 38%**	**PC: 35%**	**PC: 41%**	**PC: 32%**
	BC: 0%	**BC: 0%**	**BC: 0%**	**BC: 0%**	**BC: 0%**
	NC: 32%	**NC: 3%**	**NC: 0%**	**NC: 5%**	**NC: 8%**
	NR: 16%	**NR: 11%**	**NR: 14%**	**NR: 14%**	**NR: 11%**
	NA: 0%	**NA: 22%**	**NA: 19%**	**NA: 19%**	**NA: 24%**

Sexual Behavior Treatment Program Guide

Submitted By
SBTP Charter Workgroup
September 3, 2009

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Appendices

I. Introduction

The purpose of the Division of Juvenile Justice (DJJ) Sexual Behavior Treatment Program (SBTP) is to advance the DJJ's mission to protect the public by rehabilitating youth who are committed for a sexual behavior offense, and/or history of sexual offenses or have engaged in sexually inappropriate behavior. The SBTP is a comprehensive program focused on a continuum of care that standardizes the process for assessment and treatment planning for a SBTP youth from intake through parole.

A. Division of Juvenile Justice Programs

DJJ is committed to providing effective treatment and rehabilitative services for youth with the highest risks and needs in the State of California. Treatment programs work to enhance intrinsic motivation, target interventions through an Integrated Behavior Treatment Model and uses Motivational Interviewing (MI) and the Stages of Change.[1]

Treatment programs provide DJJ youth with individualized, integrated treatment planning to address identified risks for recidivism and the youth's criminogenic needs. It is DJJ's goal to facilitate the safe return of youth to the least restrictive environment and the community. Treatment interventions and services will be matched to the youth's needs by use of individualized clinical assessments, not just by exposure to a standardized curriculum given to all youth. Where possible, interventions used will be ones proven to be evidence-based in the research literature and include: MI, Cognitive Behavior Treatment (CBT), social skill building, direct practice, family involvement, positive reinforcement and the support of self-efficacy.

B. Sexual Behavior Treatment Program Description

The SBTP uses a collaborative treatment approach between youth and staff to develop objective Individual Treatment Plans targeting dynamic risk factors that contribute to sexual offending behavior and reoffense. Dynamic risk factors include sexual deviance, contributory attitudes, interpersonal/socio-affective functioning, self-management, and influential others (Prescott, 2007).

Standardized treatment programming (agreed upon by clinical professionals) is then tailored to the needs of the individual assigned to the SBTP. The program utilizes an interdisciplinary approach, which consists of psychosexual education, individual therapy, group therapy, family integration, psycho-educational groups, educational/vocational services, substance abuse and mental/health care services.

The SBTP maintains a standardized curriculum that includes multimedia and experiential participation by the youth, using workbooks and/or interactive journals extracted from existing research, which supports evidence based best practices. The standardized curriculum provides participating youth with information/education and exercises to assist them in making better and safer decisions in the area of sexual behavior.

[1] An assessment of an offender's motivation, commitment, and ability to change. There are five Stages of Change: Pre-Contemplation, Contemplation, Preparation, Action, and Maintenance.

1. Program Objectives:

- Provide a safe and secure environment for youth to address their treatment needs
- Provide youth with individualized interventions to address sexually inappropriate behaviors
- Decrease sexually inappropriate behaviors by providing opportunity for evidence/strength based treatment to be experienced and incorporated into the youth's new repertoire of behaviors

2. Program Elements (Rich, 2009; Schwartz, 2009):

1. Development of awareness, knowledge and enrichment of one's own thoughts and identifying the factors that influence one's thinking
2. Development of skills in empathic responding by understanding the role each person plays in relationships
3. Development of the concepts of morality and moral reasoning
4. Developing the capacity for self-regulation of impulsive thinking, feeling and actions
5. Experiencing, developing and building of trust and confidence in self and others
6. Developing the capacity for a sense of social connectedness (one's place and role in family, community and the workplace)
7. Developing self-respect and respect for others
8. Developing the ability to make decisions based on rational analysis as opposed to impulse
9. Developing the ability to recognize and express emotions
10. Developing the capacity to deal with past traumas
11. Developing the ability to recognize and interfere in one's dysfunctional patterns by the use of techniques in redirection and/or abstinence

C. Mission

SBTP is dedicated to rehabilitating youth exhibiting sexually abusive behavior, which is in direct support of the DJJ's mission to protect the public.

Youth in the SBTP will learn to:

1. Reduce and eliminate occurrence of all forms of sexually inappropriate behaviors
2. Acquire skills and knowledge to assist them in becoming responsible, healthy individuals capable of forming positive relationships
3. Develop the thinking and behavioral skills to establish a pro-social, rewarding lifestyle through participation in strength-based individualized treatment

4. Develop the ability to understand the impact of their crimes on victims, families and the community

D. Vision

The SBTP incorporates a continuum of care in which treatment occurs from intake to discharge. It is a holistic approach to treatment, incorporating the involvement of the family and community, understanding victims' rights, and simultaneously recognizing the individualized needs of every youth. The SBTP establishes a therapeutic community with an attachment-informed environment[2] to provide youth with skills and tools to learn how to develop healthy social relationships and lead successful lives. Incorporated into SBPT is a case management approach, which promotes interdisciplinary treatment team cooperation and collaboration and provides for continuous service between facilities. Respect and dignity for each individual is fundamental in this team-focused, youth-centered, therapeutic milieu.

E. Philosophy

The SBTP staff use a treatment model based on demonstrated evidence-based practices in the treatment literature, which includes a multimodal and cognitive behavior therapy approach. The development of the model and curriculum incorporates the concepts of attachment theory, evolving knowledge in neurological development and whole brain learning, as well as trauma focused therapy[3].

Continuity of staff and youth placement is important for treatment success, since youths work at learning to form healthy attachments. These bonding experiences require youth to spend sufficient time with individual staff to practice and learn from guided experience. Consequently, efforts will be made to preserve and promote these positive clinician/staff relationships by working intensively with youth to encourage them to remain in treatment.

[2] Understanding that early attachment experiences have an enduring and stable quality through the lifespan, and affect the way individuals interact with their world. (Rich, 2009)
[3] Therapy and treatment interventions that target symptoms of PTSD, depression, anxiety and behavioral symptoms secondary to trauma. (The National Child Traumatic Stress Network, 2009)

II. Entrance and Exit Criteria

A. Intake, Assessment and Placement Criteria

1. DJJ Acceptance/Rejection Criteria

The following is taken from the Acceptance and Rejection Criteria for Youth with Medical or Mental Health Conditions Policy (Institutions & Camps [I&C] 3006):

DJJ shall accept or reject a youth committed to it based on whether the youth can be materially benefited by the DJJ's rehabilitation model and educational programs, and if the DJJ has adequate facilities and staff to provide such care.

Mental Health Conditions to be Considered when Evaluating Youth:

The Chief Psychologist (or designee) shall determine whether the youth referred has required within the past six (6) months, or currently requires, mental health treatment at the acute or intermediate level of care and whether they can materially benefit from DJJ programs and services.

Medical Health Conditions to be Considered when Evaluating Youth:

DJJ does not accept youth who are seriously ill or have health impairments, or whose commitment would involve serious risk of permanent disability or long-term detriment to health status, or whose medical conditions are so extreme as to interfere with the youth's ability to materially benefit from DJJ's programs (including regular attendance at school and rehabilitative programs), or for whom DJJ does not have adequate facilities, staff or programs to provide care, and for whom DJJ cannot otherwise reasonably accommodate through modified programming or facilities.

2. DJJ Intake Procedure

Prior to being transferred to a DJJ Reception Clinic, the counties provide required documentation, including probation reports, psychological and medical evaluations (if available), Minute Orders from the court, Individual Educational Plans and special educational needs information from schools (if relevant) through the DJJ Intake and Court Services Unit.

A pre-screening is completed and if the youth is deemed appropriate for acceptance, the designated Reception Clinic (North, South, or Ventura) is notified. When the Reception Clinic receives a complete packet of documentation, an acceptance letter is sent to the Intake Department, the forwarding county and the court.

Upon arrival, each youth is photographed and fingerprinted. The fingerprint information is forwarded to the Department of Justice (DOJ). A face-to-face interview is conducted to assess any immediate risk of suicide. If there is a

specific concern regarding any mental health needs of the youth, he/she is then evaluated by a psychologist and, if deemed appropriate, by a psychiatrist.

Each youth is informed of his/her rights regarding educational and medical services. If a youth has specific registration requirements (i.e. Penal Code [PC] 290), this is then reviewed with the youth by the intake personnel.

A physical health evaluation is conducted to assess the youth's medical history, current prescribed medication and overall general well-being. Each youth is additionally interviewed by the Gang Coordinator to determine the youth's potential for gang affiliations and other potentially gang-related dangerous behaviors. Once the youth receives clearance by the intake staff, he/she is then assigned to an intake unit for general orientation and further assessments and evaluations.

The youth then participates in a series of standardized assessments regarding mental health, medical and criminogenic needs. These include:

- Treatment Needs Assessment
- Voice-Diagnostic Interview Schedule for Children
- California Youth Assessment Screening Instrument (Ca-YASI)
- Mental Health Mental Status Exam

After conducting the initial interview, an assigned Casework Specialist prepares the youth's Clinic Summary (a psychosocial history). The report identifies the high/low violence risk level of the youth and other dynamic information such as past trauma(s), previous interventions efforts, family involvement, and/or substance abuse history, The Clinic Summary also includes information regarding mandatory registration, if needed, and notification requirements for the youth prior to parole.

Within 45 days of a youth's arrival to the Reception Center, the youth participates in an Initial Case Review (ICR). This is an informational hearing facilitated by a team consisting of: a Supervising Casework Specialist, a Juvenile Parole Board member, and an Education Division representative from the facility. The youth's Clinic Summary is reviewed during the ICR and his/her program goals and needs are identified. Following this hearing, Population Management is then notified requesting a transfer for the youth from the Reception Clinic to the designated program and facility.

3. Identifying Youth in Need of Sexual Behavior Treatment

Youth meeting any of the following criteria are pre-screened and referred for placement on the SBTP:

- Youth with a 727.6 sex offense as primary or secondary commitment offense.
- Youth with a non-727.6 sex offense as primary or secondary commitment offense
- Youth meeting a required 290 registration criterion

Additional cases that do not meet the above criteria, but in which staff feel the youth may have SBTP treatment issues, will be referred to the SBTP Coordinator for review. The following process occurs when referring youth who have not met the above criteria to the SBTP program:

1. Staff contact SBTP Coordinator with name of youth and reason for referral to SBTP, including information gathered from the structured interview4.
2. SBTP Coordinator reviews information provided by staff and WIN documentation.
3. SBTP Administrative Task Force reviews cases for the appropriateness of placement on the SBTP.5
4. If placement is appropriate, youth is then transferred to the SBTP Orientation/Transition Unit.

The following will be considered when assessing a referral to the SBTP when youth do not meet above criteria (Prescott, 2007):

1. Early onset of a pattern of behavior with the youth engaging in harmful sexual behavior.
2. The persistence of sexual behavior despite detection, sanction and/or treatment
3. Clearly established deviant sexual preferences

[4] CWS and/or psychologists referring youth for placement in SBTP will follow the structured interview guidelines developed for comprehensive assessment occurring on Orientation/Transition Unit outlined in the Orientation/Transition Unit portion of the SBTP Guide.

[5] The role of the SBTP Administrative Task Force regarding placement decisions is defined in the Sexual Behavior Treatment Program Organizational Structure portion of the SBTP Guide.

4. Youth who have a history of sexual offenses but have successfully completed a treatment program, where their current commitment offense is not related to sexual abusive behavior, and/or where the youth has not displayed sexually abusive behaviors since the completion of the treatment program, will not be referred to a SBTP program. (This is specific to youth who have no 727.6 criteria).

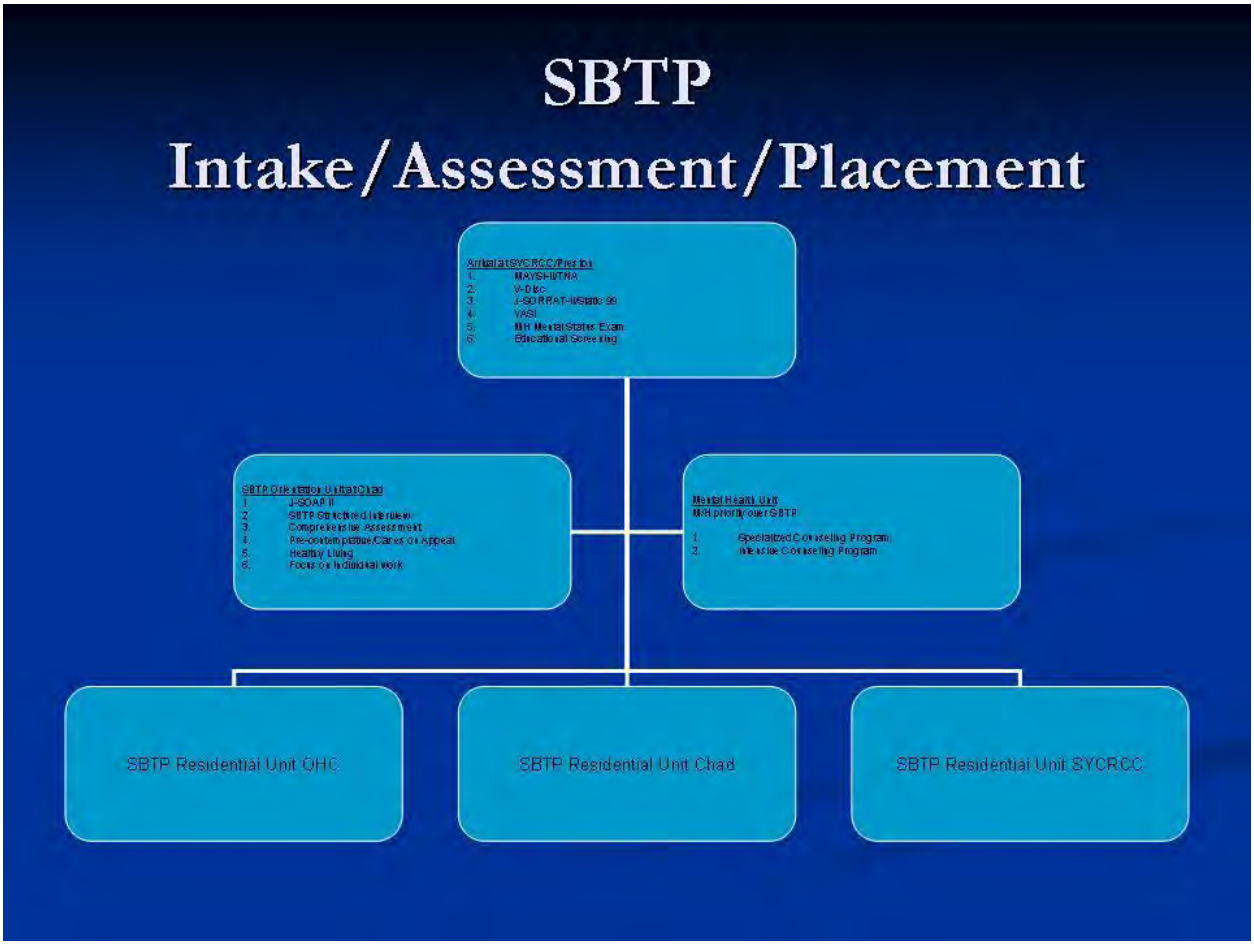
Upon the youth's arrival at a Reception Clinic, in addition to the standard assessment instruments administered, the Casework Specialist reviews the following to determine if a referral to the SBTP program is required:

- Intake and Court documents
- Community Assessment Report
- Probation Officer's reports
- Other viable documentation

For male youth, within 10 days of arrival and prior to the ICR, the Casework Specialist conducts a pre-screening utilizing the assessment tools set forth by the State Authorized Risk Assessment Tool for Sex Offenders, either the J-SORRAT-II or Static 99.

For female youth, within 10 days of arrival and prior to the Initial Case Review, the Casework Specialist screens for referral to SBTP services based on a file review of the above-mentioned information. Currently there is no risk assessment tool available for use with females. Once identified as needing SBTP services, female youth will receive Individualized Sexual Behavior Treatment, as there is no specific Female SBTP unit.

Male Youth identified in need of SBTP treatment are to be transferred to the SBTP Orientation/Transition Unit to complete their assessment process and begin their prescribed treatment. All physical placement moves will be facilitated by the SBTP Coordinator to ensure that the recommended placements are consistent with the youth's Individualized Treatment Plan (ITP).



B. Exemption Criteria

1. Youth with Mental Health Needs

Mental health issues that require a higher level of care will take priority over specific SBTP treatment. Youth with identified mental health diagnoses or active symptoms that require a higher level of care will not be placed on a SBTP unit.

Youth housed in a mental health program will receive Individualized Sexual Behavior Treatment. An ITP will be developed based on level of functioning and ability to participate in SBTP specific treatment.

Once a youth's symptoms become stabilized and it is deemed by the Treatment Team to be appropriate for the level of care to be lowered, a youth will then be transitioned into a SBTP unit once this approval to step down has been received. The SBTP Coordinator will be contacted to place the youth on the appropriate SBTP Unit.

Youth assigned to a SBTP unit who demonstrate symptoms of mental illness that may require a higher level of care will be immediately referred to a mental health program. The SBTP treatment team will work closely with the mental health receiving treatment team to modify the ITP.

2. Youth with Developmental Disabilities

Youth identified with a developmental disability making an SBTP placement inappropriate due to their level of functioning will receive Individualized Sexual Behavior Treatment. An ITP will be developed based on level of functioning and ability to participate in SBTP specific treatment.

3. Youth with Aggressive Behavioral Treatment Needs

Youth identified at the Reception Clinic as needing immediate treatment related to current levels of aggressive behavior or violence, and therefore have been recommended for placement on either an Intensive Behavior Treatment Program (IBTP) or Behavior Treatment Program, will not be placed on the SBTP unit.

Youth housed on an IBTP will receive Individualized Sexual Behavior Treatment. An ITP will be developed based on level of functioning and ability to participate in SBTP specific treatment.

Once other treatment needs have been abated and addressed, then a change in placement and/or level of care will be recommended and approved. The SBTP Coordinator will be contacted to have the youth placed on a SBTP.

C. Suspension Criteria

1. Suspension

Youth who continue to struggle with their motivation and commitment to the treatment services of the SBTP may be suspended from the program if one or more of the following occurs:

- Youth continuously refuses to attend group and individual sessions
- Youth continuously refuses to complete SBTP Stage work
- Youth continuously refuses to attend resource groups and/or complete casework assignments that accompany resource groups
- Transferring Youth to Orientation/Transition Unit to focus on the youth's specific difficulties in treatment has proven to be unsuccessful as documented through the ITP and Case Conferences
- The CA YASI identifies other criminogenic high risks that can be treated in another treatment program and/or Core unit, such as anger, negative peers or substance abuse.

- Youth has been evaluated and found **not** to have any current symptoms of a mental health diagnosis that may be interfering with the youth's ability to participate in treatment.
- Youth has been evaluated and found **not** to have any developmental or neurological symptoms that may be interfering with the youth's ability to participate in treatment.
- Youth has been evaluated by a psychiatrist and it was determined that medication would not be a beneficial intervention in addressing the youth's inability to progress in treatment.

NOTE: All documentation must clearly indicate multiple attempts to work with youth using Motivational Interviewing techniques and interventions that specifically target Stages of Change.

The SBTP Coordinator will monitor youth suspended from SBTP for eventual placement back into the SBTP. Upon completion of their other identified treatment needs, staff on the SBTP unit work closely with the receiving staff on the youth's new unit to modify the ITP.

An Interdisciplinary Treatment Team Case Conference is conducted using MI techniques. The youth will have an opportunity to express their opinion and/or make an appeal at a Juvenile Justice Administrative Committee (JJAC) hearing. A revised ITP will be required to address individual treatment that may include interventions to address the stages of change, focus on the individual's strengths to engage them in treatment, and address specific treatment needs as identified in the CA YASI.

Entrance and exit into the SBTP requires prior authorization from the SBTP Coordinator or designee. Staff on the SBTP will submit appropriate documentation related to the case conference and updated treatment plan. The ITP must include objective treatment goals the youth will address to return to the SBTP unit.

2. Aggressive and Violent Youth

Youth who are a safety and security risk due to their violent behavior towards staff or other youth and/or consistent threats towards staff or youth will be immediately removed from the SBTP unit and placed on the Behavioral Treatment Program (BTP) to address their aggressive non-compliant behavior.

An Interdisciplinary Treatment Team Case Conference is conducted using MI techniques. The youth has an opportunity to express their opinion and/or make an appeal at a JJAC hearing. A reassessment and a revised treatment plan will be required to address individual treatment needs that may include a whole host of interventions to address the stages of change, focus on the individual's strengths to engage them in treatment, and address specific behavioral concerns.

Entrance and exit into the SBTP requires prior authorization from the SBTP Coordinator or designee. Staff on the SBTP will submit appropriate documentation related to Case Conference and the youth's updated treatment plan. Individual treatment plans must include objective treatment goals that the youth will address in the BTP in order to be able to return to the SBTP unit.

While housed on the BTP, the youth's SBTP treatment team will continue to meet with them and monitor their progress. SBTP staff will work closely with the receiving BTP staff to work towards helping the youth address the identified behavioral issues. Once those treatment needs are addressed, the youth will transition back into the SBTP program. The Interdisciplinary Treatment Team will modify the Individual Treatment Plan once the youth returns; this may also include a recommendation for placement on another SBTP unit, if judged as clinically appropriate.

D. Exit Criteria

1. Cases on Appeal

Upon a successful appeal of a SBTP related charge, and if the youth meets no other criteria for placement on an SBTP unit, the youth will be transferred to the appropriate program and removed from the SBTP active list.

2. Youth who have Completed SBTP

A Post-Assessment will be completed by the youth's assigned SBTP psychologist documenting the youth's progress in treatment and completion of the program.[6] Youth who have successfully completed their SBTP treatment program and have identified treatment needs that would be better met in another DJJ treatment or education program, will be transferred from the SBTP unit and will be listed in the Ward Information Network (WIN) system as having completed treatment. The SBTP treatment team will work with the receiving treatment team to modify the Individual Treatment Plan.

Completion of the program will be determined by the following:

- Youth has completed the objectives identified in the ITP as documented through Case Conferences, Case Notes and Mental Health Chronos
- Youth has decreased their risks as identified on the CA YASI and Juvenile Sex Offender Assessment Protocol II (J-SOAP II)

The following are taken from the Juvenile Sex Offense Specific Treatment Needs and Progress Scale (Sue Righthand Ph.D., 2002, revised February 2004, November 2005) and are general treatment areas in which the youth should demonstrate progress to complete the program. Please see the Appendix under the forms section for the complete Scale.

[6] The post-assessment is outlined under the Case Planning section and the Post-Assessment template is located in the appendix of the SBTP Program Guide

- Motivation to change
- Sexual Interests
- Sexual Drive
- Social Skills
- Personal Maltreatment History
- Victim Impact/Empathy
- Attitudes/Beliefs
- Emotion/Impulse Management
- Positive/Stable Self-image
- Responsible Behavior
- Family Relationships/Supports
- Peer Relationships/Supports
- Community Supports
- Risk Management

III. Sexual Behavior Treatment Program

A. Sexual Behavior Treatment Components

The following are taken from Performance-Based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Program in Youth Correction and Detention Facilities. They are recommendations regarding the components needed to accomplish the main objectives of a SBTP.

- Group Therapy: Group therapy is often considered the primary mode of therapy for sexual behavior treatment. The purpose of group therapy is to explore the youth's daily living and interaction with others by challenging the youth to reframe how they think about their behavior, problems and relationships. Group is a process and is the avenue for deeper treatment issues to be explored.
- Individual Therapy: The goal of individual therapy is to support the work being done in the group setting. Allows staff to work with youth on individual problems or issues and to work more closely on problem areas. It also provides an avenue to develop a positive rapport between staff and youth, which is a key component to helping a youth move forward in the treatment process.
- Psycho Educational Resource Groups: These groups are used as an ancillary treatment strategy to help support, enhance the youth's daily work, and provide a foundation of understanding of treatment concepts that they will use to address their deeper treatment goals in core group. These groups are psycho-educational in nature and are presented in a didactic format.
- Journals/Homework: Individual work done outside of the therapeutic session (group, individual, family) that help youth to develop the capacity for self-awareness and self-reflection. These assignments can be maintained throughout the day or can be time-limited exercises. Assignments should be designed to help the youth work on their individual treatment objective. Agreement as to how the assignments will be shared and utilized should be discussed before hand, for example, whether it would be shared in an individual or group setting.
- Therapeutic Recreation and Leisure Activities: Therapeutic Recreation integrates program and treatment goals into recreational and leisure activities. These activities provide the arena to evaluate programmatic goals and objectives by encouraging, teaching and providing arenas to practice pro-social behavior and relationships. This allows the youth's time to be directed and monitored as he or she practices the implementation of coping skills.

B. Program Structure/Therapeutic Community

A comprehensive program to treat youth who sexually abuse must provide seamless delivery of services from custodial care to clinical services. Treatment cannot happen in an unsafe environment, whereas appropriate treatment will increase the safety of the unit. Having a therapeutic atmosphere emphasizing respect and supportive relationships, while reinforcing responsible and pro-social behavior, is a key component to a successful treatment program. (Performance-based Standards for Youth Correction

and Detention Facilities a Resource Guide: Sex Offender Programming in Youth Correction and Detention Facilities).

A therapeutic community is a living unit totally devoted to the comprehensive treatment of the resident sex offender. All personnel working on the unit have prerequisite training in MI, CBT and SBTP curriculum and can facilitate the issues and concerns often engaged in by the youth in treatment.

"Fairness, consistency, and predictability are crucial features of the environment and culture of the treatment program. The following structural elements are essential constituents of sex offender programs in juvenile correctional facilities": (Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Programming in Youth Correction and Detention Facilities).

- Pro-social Peer Community
- Behavior Management System
- Level System

The following are recommendations made by The National Task Force Report in 1993 specifying things that should be in place in every Sexual Behavior Treatment Program. (Performance-based Standards for Youth Correction and Detention Facilities a Resource Guide: Sex Offender Programming in Youth Correction and Detention Facilities).

1. A systems-based program designed for sexual abuse prevention in the institutional setting, which includes:
    - Policies and procedures reflecting an open and safe system, which addresses safety, youth's rights and familial rights
    - Procedures for selecting, screening, training and supervising staff to decrease the risk of sexually abusive behavior
    - Staff guidelines for interventions with residents
    - Safety education for residents
    - Protocols ensuring environmental safety
    - Procedures addressing allegations or disclosures of sexual abuse
    - Internal evaluations and external reviews
2. A strong, structured behavior management program where management and control of behavior are maintained through program structure and staff/resident interactions
3. A safe therapeutic environment and effective therapeutic milieu
4. Close staff supervision based on a high staff-resident ratio, and continuous monitoring by staff of all interactions
5. A therapeutic milieu, which includes a facility safe environment, secure space, and strong peer culture, and a program philosophy that is consistent throughout

6. A structured, well-balanced program, which provides modalities developed to impact adolescent problems, and which allows very little unstructured time
7. Highly trained staff who has received specialized training in youth sexual abuse issues, with emphasis on treatment of youthful victims and sexually abusive youth
8. A multidisciplinary, multimodal design to impact the treatment issues of both victims and sexually abusive youth
9. A positive human sexuality program that emphasizes the development of positive attitudes about sexuality, healthy relationships, and safe sexual practices
10. On-going, planned program evaluations

C. Sexual Behavior Treatment Program Placement

- SBTP Orientation/Transition
- Healthy Living Treatment
- Residential Sexual Behavior Treatment
- Individualized Sexual Behavior Treatment
- Female Sexual Behavior Treatment

1. SBTP Orientation/Transition

Youth identified as needing of SBTP treatment will initially be placed on the SBTP Orientation/Transition Unit. Ten days after arrival the youth will complete a Comprehensive SBTP assessment resulting in the development of the youth's initial ITP. After the completion of the treatment plan, all SBTP youth are assigned to begin receiving and complete Healthy Living Treatment.

Case Conference will be held in accordance with the assigned living unit policy but no later than every 60 days. During Case Conference, the Interdisciplinary Treatment Team will discuss progress the youth has made in the SBTP Orientation/Transition unit as identified in the Individual Treatment Plan.

Completion of the Orientation Phase of treatment is individualized. The youth's ITP outlines treatment objectives that signify readiness to progress to a SBTP residential unit. The Orientation Phase is designed to be short-term, but actual length of stay will be individually determined based on treatment needs.

Efforts are made to transition youth whose long-term placement will be in a Southern Facility to a Residential unit shortly after completion of Healthy Living Treatment, particularly if consistent contact with the family is clinically beneficial towards making progress in treatment.

a. Pre-Contemplation Stages of Change Treatment

SBTP youth in the Pre-Contemplation Stage of the Stages of Change may remain on the SBTP Orientation/Transition Unit. The treatment team develops an ITP, specifically using MI techniques, to address and help youth identify where they are, vis a vis the Stages of Change, in an effort to move the youth forward in their internal motivation to complete the SBTP program. Youth who fit this category may include:

- Treatment refusals
- Active trauma symptoms7
- Emotional dissociation8

If a youth continues to refuse to participate in the SBTP, appropriate sanctions and resulting consequences are applied in accordance with the DJJ Disciplinary Decision Making System (DDMS) policy (I&C Manual Section 7300-7394) and discussed with the youth. Not participating in prescribed treatment may impact their ability to partake in the youth incentive program. Any mitigating circumstances, such as mental health issues, are taken into consideration.

b. Cases on Appeal: Allowances and Procedures to Continue with SBTP

Youth are documented as having a "Case on Appeal", specifically related to the issue of sustaining a sexual offense (not related to the disposition for a sustained sexual offense will remain on the SBTP orientation unit. Appeals not related to the youth's sexual behavior history will not interrupt the youth being placed on a residential SBTP unit. The treatment team will develop an appropriate Individual Treatment Plan that focuses on other identified treatment needs until the appeal is resolved. The following outlines the procedure for documenting Cases on Appeal:

1. Participants who claim to have an appeal pending and report that they are unable to participate in SBTP will be required to provide a copy of the Writ of Appeal and a letter from their attorney that includes the following sentence:

   "Based on his/her current court appeal, my client cannot discuss the case and/or speak about the elements of the (alleged) offense(s)."

2. The assigned SBTP Casework Specialist or designee will identify and contact the youth's attorney. The attorney has 20 days to respond to DJJ's request for status of youth's appeal.

[7] Eating and sleep disturbances, low energy, depression, anxiety, difficulty making decisions and/or decreased ability to concentrate.
[8] A state in which a person's emotions become separated from the rest of the personality, in turn youth have difficultly identifying and expressing emotions.

3. If the response is not received within the identified timeframe, the facility Parole Agent III will make contact via telephone, fax, or electronic device and document attempts.

4. Upon receipt of the attorney's response, the Parole Agent III will forward the response to the SBTP Coordinator, assigned Casework Specialist and youth.

5. The Public Defender's Office or County Probation Department may be able to assist in locating the attorney of record in the event the PA III has difficulty locating or contacting a youth's attorney.

6. If the attorney confirms that the youth cannot discuss the case or speak about the alleged offense(s) based upon a court appeal, the youth will remain on the SBTP Orientation Unit or on another DJJ unit in accordance with the youth's needs.

7. If it is determined that there is no appeal pending or the appeal is denied, the youth will be assigned to Residential Sexual Behavior Treatment as prescribed in the youth's Individual Treatment Plan. The youth shall **not** be subject to any disciplinary sanctions for his/her failure to participate in residential treatment due to an appeal pending, particularly if youth believed an appeal was pending when it was not.

8. If the appeal is granted the youth will then be moved to the appropriate DJJ program if he or she remains in a DJJ facility[9].

The SBTP Coordinator will track the status of the court appeal to expedite the youth's appropriate placement.

c. Youth who are Resistive to Treatment

Youth who are placed on a residential SBTP unit but are struggling with their treatment may be recommended to return back to the orientation unit if it appears this is clinically appropriate to help the youth make progress in Stages of Change and better facilitate treatment.

An Interdisciplinary Treatment Team Case Conference is conducted on behalf of youth that are reluctant to participate in the SBTP, using MI techniques. The youth are given an opportunity to express their opinion and/or make an appeal at a JJAC hearing. A revised Individual Treatment Plan will be required to address individual treatment needs that may include identified interventions to address the need to engage in treatment according to their level of readiness as identified in the Stages of Change. Focus is placed on the individual's strengths and their abilities to be engaged in treatment.

Entrance into and exit from the SBTP requires prior authorization from the SBTP Coordinator or designee. Staff on the SBTP programs will submit appropriate documentation related to the case conference and

[9] See Exit Criteria portion of SBTP Guide for procedure related to successful appeals.

intermittently updated Individual Treatment Plans. The individual plans include treatment objectives the youth will address in the orientation unit in order to return to the residential unit.

d. Family Counseling

The SBTP Orientation/Transition Unit provides the first opportunity to involve the youth's family/guardian, when appropriate, as prescribed in the treatment process. Family members are provided an opportunity to attend a Family Orientation Workshop, as well as schedule the first of a series of planned family sessions that will occur throughout the SBTP. Family sessions conducted during the Orientation Phase involve meeting with the Treatment Team to discuss the ITP, Stages of Change and any unwillingness of the youth to participate in treatment, as well as discuss the identified treatment goals for completion of the program.

Youth whose families reside in the south will be encouraged to participate in Family Counseling through either video conference or conference calls. Every effort will be made to ensure that the family and youth remain connected during the Orientation phase of the program.

The Family Orientation Workshop involves the following:

- Family members are invited to attend a workshop, which will include a basic overview of the SBTP
- Included in the overview is a discussion on the SBTP treatment process, curriculum and overview of the youth's daily living
- An opportunity for family members to meet staff on the SBTP program
- An opportunity for family members to ask questions related to DJJ or the SBTP
- Introduction of Family Counseling Sessions and discussion regarding why sessions are an important aspect in SBTP treatment

The guidelines for Family Contact/Counseling are the following:

- Per policy, youth will be allowed to contact their family upon arrival to the Orientation/Transition Unit
- Per policy, families will be contacted after the Initial Case Conference
- During the Initial Case Conference, the assigned psychologist will use the SBTP Parent Assessment Form[10] to determine appropriateness of scheduling family sessions

[10] The Parent Assessment Form is located in the Appendix of the SBTP Program Guide.

- If the family is willing and appropriate for involvement in treatment, the assigned psychologist will contact the family to schedule an initial family session.

The objectives of the Family Sessions during the orientation phase are the following:

- Orient the family to the treatment process and the SBTP.
- Review the ITP
- Treatment objectives for family sessions during the Orientation Phase should be short-term and psycho-educational in nature. More in-depth and process-focused sessions occur once the youth is placed on a Residential Unit where treatment is long term.
- For youth struggling with their motivation and who are in the Pre-contemplation Stage of Change, sessions will focus on increasing motivation and helping to strengthen family support during the treatment process.
- A family's unwillingness to participate in Family Counseling or indications that contact with the family is inappropriate should be clearly documented on the SBTP Parent Assessment Form and in the ITP The ITP should also contain what progress or behaviors should be demonstrated by youth and/or family that would make the family sessions appropriate.

If a family wishes to participate in the treatment process but there are clinical concerns regarding their participation and its effect on the youth's progress, the following will occur:

- The family will continue to have contact with the treatment team in accordance with policy. (Case Conference, JJAC hearings, etc). This will allow the family to remain connected to the youth and the treatment team.
- SBTP staff will help the family make contact with Victim Services, who could provide the family with resources in the community to provide support and help them prepare for family sessions.
- Whether the family is ready to start family sessions should be re-evaluated at every case conference and clearly documented as to why or why not it is appropriate. If found inappropriate, documentation should indicate what objectives need to be met for family sessions to begin.

e. Transition Phase

Youth having completed the SBTP Residential program and who, according to the ITP, are not awaiting a more appropriate placement on another DJJ unit, will be returned to the SBTP Orientation/Transition unit.

Transition youth on the orientation unit will act as mentors to new SBTP youth. They will attend the transition groups and the Individual Treatment Plan will be adapted to reflect a change in treatment goals that will include a focus on reentry and transitioning back into the community. Reentry treatment goals will focus on skills needed to be a successful and independent individual in the community, including job skills, housing issues, acquisition of a vocational skill, completion of education and life skills such as learning how to pay bills, dress appropriately and balance a checkbook.

The transition phase allows for a change in their assigned environment to enable them to practice the skills and interventions previously been learned in the Residential program, while also providing support and structure to maintain their progress.

Completion of the transition phase will be determined by the Treatment Team who will monitor their progress and help them to focus on their parole release date.

For youth residing in a southern facility, placement on the transition unit will be made on a case-by-case basis based on the following considerations:

- Youth's family has been actively involved in the treatment process and family sessions and therefore placement in the Transition/Orientation Unit will disrupt the transition process.
- The Individual Treatment Plan involves the youth's receiving treatment team (group home staff, contract therapist) having regular contact that is more appropriate face-to-face versus conducting video/phone conferences.
- Youth who remain at a southern facility will be evaluated for placement on a pre-parole program, which may better serve their treatment needs. This may include evaluation for placement in Camp. If placement on a pre-parole program is appropriate, Individualized SBTP treatment will be provided.

f. Treatment Hours

Treatment hours on the Orientation/Transition Unit are a minimum of **6** hours per week, with the exception of institution emergencies. The following breakdown of treatment hours is recommended as part of the identified curriculum per week; however, specific treatment recommendations will be identified in the Individual Treatment Plan:

Required Therapy Hours:

- Two 90 minute groups (3 hrs total): Healthy Living group co-facilitated by a Psychologist and Youth Correctional Counselor (YCC) in a small group setting for youth in the Orientation Phase

or two 90 minute groups (3 hrs total) Transition Group co-facilitated by a Psychologist and Youth Correctional Counselor for youth in the Transition phase.

- 1 hr Resource group
- 1 hr Individual Therapy (½ hr MH professional, ½ hr YCC)
- 1 hr homework on stage, individual or journal assignments that support therapy

Required Community Treatment Hours:

- 2 hrs Residential large group led by the Senior Youth Correctional Counselor to include treatment services and/or community services.

Each treatment team member (YCC, Psychologist, and Casework Specialist) will sign off all treatment plans either during the case conference process or during a SBTP Team Staffing. Any treatment plans that modify the above recommendation or result in the total treatment time being less than the minimum requirement of 6 hours need to be clearly documented and clinically justified through the assessment process and ITP. Treatment hour overrides need to be approved and signed off by both the Program Administrator and Senior Psychologist.

If there is a disagreement within the Treatment Team on a youth's Individual Treatment Plan that cannot be resolved between the Treatment Team members, a special staffing, which will include the Program Administration and Senior Psychologist, will occur and there will be a consensus reached on the Individual Treatment Plan. If a consensus cannot be reached after the special staffing, an administrative staffing will occur. The administrative staffing will include the Program Administrator, Senior Psychologist, Chief Psychologist, Superintendent and SBTP Coordinator. Once agreement on the Individual Treatment Plan has occurred, the SBTP Coordinator will review the circumstances of the disagreement to evaluate the need for training, team building, supervision and/or a Correction Action Plan to increase and support long-term Treatment Team communication and synchronization.

Treatment hour overrides are tracked by the SBTP Coordinator and monitored through the Quality Assurance Plan to evaluate whether the process functions appropriately as well as to assess the number of exceptions occurring.[11]

g. Healthy Living Treatment

Healthy Living Treatment is a short-term psycho-education program designed to be the foundation for the SBTP, as well as provide treatment

[11] Documentation required for override of minimum required hours of treatment is located in the Appendix in the SBTP Program Guide.

to those youth identified in the lowest risk category or youth who have no previous sexual behavior history, but have received DDMS related to sexual behaviors as defined in the Sexual Misconduct Policy. The Healthy Living Program provides didactic information/education and dynamic role-play opportunities, along with written and verbal exercises, to assist youth in reducing their risk of future sexual offenses.

The Healthy Living curriculum assists and equips youth with information and choices to enable them to make better decisions in the area of sexual behaviors and relationships. Youth will develop an increased awareness of their physical and psychological health and become acquainted with the breadth of laws related to sexual behavior. They will receive exposure to healthy and positive ways of relating to issues of sexuality with acquisition of knowledge, attitudes and beliefs for having healthy relationships.

2. Residential Sexual Behavior Treatment

Residential treatment provides an intense therapeutic community and various services including:

- Individual treatment based on risk of recidivism and offense dynamics.
- Specific abusive/offending Sexual Behavior Treatment.
- Psycho-educational Resource groups.
- Clinical Resource groups.
- Individual counseling.
- Family sessions.
- Frequent re-assessment of dynamic sexual offending risk factors, including both criminogenic factors and protective factors that are on going. This information is used to inform any modifications to be made to the youth's ITP.

Treatment hours for residential treatment are a minimum of **6** hours per week, with the exception of institution emergencies. The following is recommended as part of the identified services per week; however, specific treatment recommendations will be identified in the case plan:

Required Therapy Hours:

- Two 90 min Core groups (3 hours total) co-facilitated by a Psychologist and a Youth Correctional Counselor (YCC) in a small group setting
- 1 hr Resource group
- 1 hr Individual Therapy (½ hr MH professional, ½ hr YCC)
- 1 hr homework on stage, individual or journal assignments that support therapy

Required Community Treatment Hours:

- 2 hrs Residential large group led by the Senior Youth Correctional Counselor to include treatment services and/or community services.

The entire treatment team (YCC, Psychologist, and Casework Specialist) sign off all treatment plans during the case conference process or during a SBTP Team Staffing. Any treatment plans that modify the above recommendation or result in the total treatment time being less than the minimum requirement of 6 hours need to be clearly documented and clinically justified through the assessment process and ITP. Treatment hour overrides must be approved and signed off by the Program Administrator and Senior Psychologist.

If there is a disagreement within the Treatment Team on a youth's Individual Treatment Plan that cannot be resolved between the Treatment Team members, a special staffing, which will include the Program Administration and Senior Psychologist, will occur and there will be a consensus reached on the Individual Treatment Plan. If a consensus cannot be reached after the special staffing, an administrative staffing will occur. The administrative staffing will include the Program Administrator, Senior Psychologist, Chief Psychologist, Superintendent and SBTP Coordinator. Once agreement on the Individual Treatment Plan has occurred, the SBTP Coordinator will review the circumstances of the disagreement to evaluate the need for training, team building, supervision and/or a Correction Action Plan to increase and support long-term Treatment Team communication and synchronization

Overrides are tracked by the SBTP Coordinator and monitored through the Quality Assurance Plan to evaluate whether the process functions appropriately as well as to assess the number of exceptions occurring.[12]

a. Family Counseling

Residential Sexual Behavior Treatment includes a Family Counseling component. If deemed appropriate and the families are willing and able to participate, the Psychologist and/or Casework Specialist will provide counseling sessions to the family.

The guidelines for family contact are the following:

- Per policy, youth will be allowed to contact their family upon arrival to the Residential Unit.
- Per policy, families will be contacted after the initial Case Conference.
- During the initial Case Conference after a youth arrives to a Residential unit, the Treatment Team will assess for

[12] Documentation required for override of minimum required hours of treatment is located in the Appendix of the SBTP Guide.

appropriateness of family involvement utilizing the SBTP Family Assessment Form[13]. A copy of this form will be placed in both the Unit and UHR files.

- If the family had previous involvement during the Orientation Phase, the treatment team will review the previous family counseling goals and modify based on treatment need.
- All Family Counseling goals will include in the ITP.
- If the family does not appear to be ready, willing or appropriate to begin family counseling, the reasons will be clearly documented on the SBTP Family Assessment Form.
- If a family wishes to participate in the treatment process but there are clinical concerns regarding their participation and its effect on the youth's progress, the following will occur:
    1. The family will continue to have contact with the treatment team in accordance with policy. (Case Conference, JJAC hearings etc.). This will allow the family to remain connected to the youth and the treatment team.
    2. The family will be evaluated to determine what amount of contact, if any, would be appropriate for the family sessions based on the identified concerns. For example, sessions may focus more on psycho-educational material related to the treatment process if family does not currently appear capable of dealing with deeper treatment issues. These reasons will be clearly documented in the treatment plan.
    3. SBTP staff will help the family make contact with Victim Services, who could provide the family with resources in the community to provide support and help them prepare for family sessions.
- At each Case Conference, the assigned psychologist will fill out the SBTP Family Counseling Update Form[14] documenting any changes with family counseling sessions. If a family was previously found not ready, unwilling or inappropriate for family counseling, this will be monitored and reevaluated during Case Conference to ensure Family Sessions occur if situations have changed.

Specific Family Counseling Goals will be determined based on what is appropriate given the families' treatment needs. General objectives of Family Counseling during the Residential phase are the following:

- Review the Individual Treatment Plan

[13] The Parent Assessment Form is located in the Appendix of the SBTP Program Guide.
[14] The SBTP Family Counseling Update Form is located in the Appendix of the SBTP Guide.

- Develop specific objective treatment goals and a treatment schedule (how often family will meet) to be included in the youth's Individual Treatment Plan
- Involve the family in the Treatment Process
- Provide a forum for the youth to share treatment work with family members
- Discuss youth's release back into the community, specifically addressing the impact on family interaction
- Inform and discuss how current sex offender laws will impact youth upon his or her release

b. Family Reunification Sessions

When the youth is deemed by his treatment team to be ready to engage in family reunification, victim/offender mediation, and/or family therapy, and the victim is a family member, the following is recommended:

- Prior to the start of Family Reunification Sessions, the youth's Treatment Team will conduct a SBTP Team Staffing to ensure that all Treatment Team Members agree with the appropriateness of Reunification Sessions.
- Clinical staff coordinates with the Office of Victim and Survivor Rights & Services (OVSRS) staff to facilitate a neutral point of contact and ensure victim rights are safeguarded.
- The offender must accept full responsibility for his actions in order to cease any further injury to the victim.
- The clinician must remain sensitive to victim issues and ensure that the offender and or family are not minimizing the behaviors during the session.
- The victim will be afforded the option of requesting the presence of a support person during the session.
- When the victim is a minor, the parents must be present and a part of the family counseling.
- The victim must have participated in therapy prior to engaging in family therapy in the SBTP. It is important that the victim have a therapeutic support system outside the SBTP clinician.
- Written recommendation from the victim's therapist will be obtained prior to moving forward with family sessions. (Release of information should be signed by all parties) If the victim's therapist does not recommend family sessions, sessions will not occur.
- The SBTP psychologist is encouraged to seek consultation with the victim's therapist in order to be aware of any significant family dynamics to be addressed during treatment. If no response, the

psychologist should request release of info and review appropriate documentation prior to meeting.

- The SBTP psychologist will receive supervision by the Senior Psychologist and/or shall present the case during Mental Health Treatment Team meetings to review progress and appropriateness of youth contact with their victim.
- Debriefing with youth after session will be conducted to assess mental status and need for additional support.

3. Individualized Sexual Behavior Treatment

Individualized Sexual Behavior Treatment is for youth placed on the ITP, IBTP or the Specialized Counseling Program (SCP). SBTP will be provided to youth identified as requiring Sexual Behavior Treatment but due to a primary risk/need that takes priority over SBTP, such as mental health and institutional violence, will not be placed on a SBTP unit until that primary risk/need is addressed.

Individualized Sexual Behavior Treatment will include the following:

- Individualized Sexual Behavior Treatment will be provided by the assigned MH clinician on the youth's assigned unit.
- The clinician will follow the curriculum of the SBTP when providing specific SBTP treatment.
- Youth's Individual Treatment Plan will specify the Sexual Behavior Treatment objectives, including how treatment will be provided (individual, group and/or family).
- Youth's treatment hours will be consistent with the treatment hours required for their specific treatment unit.
- If a youth is determined that their level of care has been raised to Core and they have not completed the SBTP, the youth will be recommended for Residential Sexual Behavior Treatment. The sending and receiving treatment teams will work together to modify the Individual Treatment Plan. The stage of work the youth has successfully completed will be taken into consideration when determining what stage of treatment the youth will be placed on when transferred to the Residential Unit.

Case Conference shall be held in accordance with the assigned living unit policy but no later than every 120 days. During the Case Conference, the interdisciplinary treatment team along with the youth will identify and discuss progress on treatment, parole/community re-entry planning, and goal setting and develop a case management plan

4. Female Sexual Behavior Treatment

Treatment of juvenile females who sexually abuse is a specialized field and a difficult population to study. The area of juvenile female sex offenses lacks sufficient research. The research that has been conducted tends to be based on small sample sizes and lacks strong data and analyses from which to draw any valid inferences.

Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Program in Youth Correction and Detention Facilities reviewed the research on Female Offenders, which suggests the following:

- Adolescent female offenders tend to commit multiple acts of sexual abuse against younger family members, often in care giving situations.
- They tend to be of average intelligence but experience academic and behavioral problems in school.
- They oftentimes engage in a variety of delinquent behaviors, including substance abuse.
- They suffer from emotional and psychological difficulties, evidenced by suicide attempts, anxiety, depression, and Post Traumatic Stress Disorder.
- They oftentimes come from unstable homes where there may be numerous forms of abuse and maltreatment.
- They tend to have high rates of sexual victimization themselves. In many cases, they have been victimized by more than one offender. The abuse usually begins at an early age and happens on multiple occasions.
- Although there is not much research, experts agree that Female Juvenile Sexual Behavior Treatment needs to take a different approach than the Male Juvenile Sexual Behavior Treatment.

Currently there is no specific SBTP unit for females identified as in need of SBTP services; therefore Individualized Sexual Behavior Treatment is provided for DJJ's female sexually abusive youth. The Female Sexual Behavior Treatment curriculum will be separate from the curriculum used by the male SBTP population. It will focus on the specific needs of this population.

C. Case Planning

A comprehensive and continuous assessment is an integral part of the SBTP. Having the ability to provide individualized treatment comes from assessing and monitoring a youth's progress. Assessments at the front-end of treatment help to determine risk levels, treatment needs and programming for the youth. Interventions throughout the treatment program help to prepare each youth for reintegration into the community. The Case Planning and Review Process provide administrative oversight for each youth's movement through DJJ and ensure that parole and reentry planning effectively meets the risk level and needs of offenders being released into the community. (Performance-

based Standards for Youth Correction and Detention Facilities a Resource Guide: Sex Offender Programming in Youth Correction and Detention Facilities.)

1. Orientation/Transition Unit

Within 10 days of the youth being placed in the Sexual Behavior Treatment Orientation/Transition Unit, a clinician will administer a comprehensive assessment to determine those dynamic factors the Treatment Team will target to reduce the risk of the youth to sexually reoffend. The results of the assessment will be used in developing an ITP (Risk Management/Needs/Safety assessment) which will address the youth's sexual behaviors and criminogenic needs. The comprehensive SBTP assessment will include[15]:

- J-Soap-II
- Current Trauma Symptom (information will be gathered from the initial MH Mental Status Exam, which includes a trauma screening)
- Screening For Processing Difficulties (if needed, youth will be referred to the school psychologist for a full evaluation)
- Attachment Issues
- Sexual Behavior Specific Assessment for high risk offenders (Midsa)
- Personality Assessment (MACI/MCMI-III)
- Neuro-psych Screening
- CA YASI

The ITP (Risk Management/Needs/Safety assessment) will focus on outlining individual dynamic risks. It will outline treatment objectives for progress in the program and the objectives that should be accomplished for successful completion of the SBTP.

There are three levels of risk to consider when determining treatment planning: Low, Moderate and High risk for sexually reoffending.

Given the dynamics of the youth's specific offense, the needs of the youth at low risk to re-offend sexually may be best addressed by utilizing a psycho-educational didactic treatment model. Youth at moderate risk to re-offend sexually will receive treatment modalities focused on socially appropriate sexual behaviors. High-risk offenders to reoffend sexually are the youth who will receive intensive treatment modalities, focusing on deviant sexual behaviors specifically addressing deviant patterns of sexual behavior and ways to change them to socially acceptable behaviors.

[15] Specific assessments and components of the SBTP Comprehensive Assessment will be modified as research-identified best practices indicate additions or deletions. All modifications will be approved by the SBTP Administrative Task Force prior to changes to assessment process.

2. Residential SBTP Units

Within the first 5 weeks of arrival, the youth and his or her assigned treatment team will participate in an Initial Case Conference. The treatment team will review the youth's current ITP and make any modifications necessary to begin residential treatment.

Case Conferences will be held at least every 60 days and will include the Interdisciplinary Treatment Team. The Case Conference will identify and discuss progress on treatment, parole community reentry planning, goal setting and develop a case management plan for the next case conference.

3. CA YASI and J-SOAP II Re-assessment

The CA YASI will be re-administered per policy in accordance with the Case Conference Schedule.

J-SOAP II will also be re-administered in accordance with the Case Conference Schedule. Both assessments will be used to update the Individual Treatment Plan based on the progress or lack of progress indicated.

4. Post-Assessment

Upon completion of the SBTP, youth will receive a post assessment that will be conducted by a SBTP psychologist[16]. The post-assessment will include the following information:

- Treatment summary
- CA YASI
- J-SOAP-II if under age 18/ STABLE if over the age of 18
- Sexual Behavior Specific Assessment (Misda)
- Personality assessment
- Pre-release risk assessment

The post-assessment focuses on the youth's treatment progress, and a reduction or increase in the youth's risk level. This includes assessing the following:

- Static risk factors
- Dynamic risk factors
- Protective risk factors

D. Resource Groups

[16] The Post-Assessment template is located in the Appendix of SBTP Program Guide.

Resource Groups will be offered to supplement the SBTP Core Curriculum and will be offered to youth based on treatment needs and treatment objectives identified in the ITP. Therefore, not all youth will need to complete the same resource groups; placement in a group will be based solely on treatment need.

As mentioned under SBTP Treatment Components, SBTP resource groups are primarily psycho-educational in nature and didactic in their format. The main objective of a resource group is to provide information and knowledge that will be used in core group therapy. Resource groups are designed to provide accurate information and knowledge, clarify misconceptions and dispel myths that support and/or encourage abusive behavior as well as provide skill building to help the youth develop coping skills and strategies to make better choices. (Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Program in Youth Correction and Detention Facilities.)

The following Resource Groups will be offered on the SBTP Orientation/ Transition Unit:

- Pre-Contemplative Group
- Substance Abuse
- Stress Management

The following Clinical Resource Groups will be offered on the SBTP Orientation/Transition Unit:

- Dialectical Behavioral Therapy (DBT) Group/ Dealing with Difficult Emotions

The following Resource Groups will be offered on the SBTP Residential Units:

- Assertiveness Training
- The Sexual Assault Cycle
- Cognitive Restructuring
- Social Skills Training
- Substance Abuse
- Stress Management
- Interpersonal Skills
- Victims Awareness
- Neuro-criminology

The following Clinical Resource Groups will be offered on SBTP Residential Units:

- Survivors
- DBT Group/ Dealing with Difficult Emotions

1. CA YASI Resource Groups

Per policy regarding the CA YASI 10 Dynamic Domains of risk, specific resource groups will be offered to target each youth's specific high risks. The 10 Dynamic Domains include:

- Violence/Aggression
- Social Influence
- Substance Abuse
- Attitudes
- Social/Cognitive Skills
- Education/Employment
- Family
- Health
- Community Linkages
- Community Stability

Youth will be assigned to specific interventions/resource groups based on the need identified on their CA YASI. The CA YASI resource groups include:

- Aggressive Replacement Training (ART)
- Counterpoint
- CALM
- Strategies for Self Improvement and Change
- Pathways
- Transition Skills
- Girls Moving On

E. SBTP Community Committees

As a part of maintaining a therapeutic atmosphere on the SBTP, youth will be encouraged to create and develop SBTP Community Committees. SBTP Community Committees will cover:

- Governing aspects of the rules and operation of the unit
- Organization of unit activities
- Restorative justice or victim outreach

- Peer mentoring
- Youth and staff working together

Every SBTP unit will have at a minimum two SBTP Community Committees active at all times. Youth will be encouraged during large group to contribute ideas for Committees.

SBTP Committee meetings and activities will be documented and stored in a binder on each unit. Documentation will include the following:

- Description and name of SBTP Community Committee
- Committee membership
- Documentation of the members participation in the committee
- Documentation of Community Committee meeting minutes

F. Victim Services

1. Victim Notification and Related Services

Upon receipt of a victim request for notification, legal mandates require that the victim be notified 30 days prior to hearings. DJJ Policy requires **45-day notice** for the facilities to complete the letters and submit them to OVSRS for processing and notification within the mandated time frames.

SBTP staff will review the Victim's Notification checklist, which specifies what notifications the victim has requested. Staff will to ensure that procedure and time frames are followed specific to those requests.

In cases on the SBTP where the victim is a relative of the offender, staff must insure adherence to the notification policy regardless of the offender/victim relationship. OVSRS will ensure that all victim rights are enforced and services offered will be commensurate with the need of the victim and family. There are often complex family dynamics that can best be facilitated with the assistance of OVSRS. SBTP clinical staff is encouraged to utilize OVSRS for consultation on cases when consideration is being given to family therapy and the victim is a family member.

OVSR offers a variety of services and resources:

- OVSRS provides specific victim related training for staff to enhance case work and counseling for the offenders
- OVSRS also assists the SBTP staff in securing victim speakers to address the offenders and increase their understanding of the impact of crime on the lives of victims
- OVSRS can provide resources to families, including a list of service providers and possible funding available to help pay for counseling services to those families who also have a victim in the home

G. Continuum of Care

"The optimal continuum of services, in providing a coordinated range of programs, of the system. The nature and intent of programming remains constant as youth progress along the continuum. Collaboration and effective ongoing communication are key elements in an optimal continuum of sex offender services. Interagency collaboration is a fundamental element of parole and community services in the effort to maximize public safety. An optimal continuum of services requires an undergirding philosophy and consistent guiding principles which ensure coherence in service delivery. Planning, collaboration, and communication are foundational elements in matching program to risks levels and needs and to the transition and reintegration of youth into the community." (Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Program in Youth Correction and Detention Facilities.)

Parole Services Manual (PSM) 4125 General Policy: The purpose of the pre-placement contact between Parole and Juvenile Facilities staff is to seek all available significant information about the youth in order to plan most effectively for public safety measures and the placement program. The pre-placement contact will normally be made by telephone, given the logistic constraints of time and distance. Whenever practical, however, Parole staff will attempt to personally visit the facility to meet with staff and if possible to interview the youth. Some of these contacts can be accomplished in the context of participation in Juvenile Facilities pre-parole programs.

SBTP youth require similar facility and parole services as other youth in either a specialized treatment program or a general population program. SBTP youth may have co-occurring psychological disorders, physical or academic limitations or substance abuse issues. Therefore, in addition to SBTP treatment, their inclusion in facility and parole services is critical towards lowering their risk of either violating their conditions of parole or receiving new criminal charges.

The benefits of conducting discharge planning early in the youth's treatment process include[17]:

- Provides linkage to appropriate next step resources based on treatment need
- Reduces reverting to methods of survival that often are self-destructive
- Prevents vulnerable populations from becoming homeless
- Supports maintenance of gains achieved during the course of incarceration.

1. Field Parole Agent Prior to Youth's Release

The field Parole Agent will participate in the pre-parole case conference, 6 months prior to the Projected Board Date (PBD) with the facility treatment team. The field Parole Agent provides resources to the youth that include

[17] Best Practices Manual for Discharge Planning, Baron, Erlenbusch, Moran, O'Connor, Rice, Rodriguez and Salazar, July 2008

contracted providers, i.e. outpatient services for sex offender therapists in the community and/or group home provider.

- The field parole office will provide training opportunities for agents with a specialized caseload.
- The field parole office will notify local law enforcement agencies of the youth's pending release.
- The field parole office will have contracted group homes for youth who require an out of home placement.
- The field parole agent will have contracted services for post-facility counseling.
- When possible, the field Parole Agent will meet with the youth, his or her immediate family (if appropriate), and facility staff prior to the youth's release.

H. Parole

1. Information that is provided to Field Parole

- Request for Parole Placement Plans
- Initial report to parole – 6 months prior to PBD
    1. Summary of youth's progress in treatment
    2. Pre-release risk assessment
    3. Probable placement location and contact information
    4. Identify need for out-of-county placement, if necessary; this should be initiated if possible 12-8 months prior to parole
    5. Other information (i.e. gang affiliation, potential employment opportunities, academic status, citizenship status
- Addendum to initial report to parole – 2 months prior to PDB
    1. Updated summary of youth's progress in treatment
    2. Youth's relapse prevention plan
    3. Confirmed placement location and contact information
- List of medications or special needs of youth

2. Training Requirements for Parole Agents

- Risk Assessments and Re-Entry Services
- Community Supervision
- Yearly Training on SBTP curriculum
- Containment Model

I. Pre-Release Assessments SARATSO SB 1128

Senate Bill (SB) 1128, Alquist (Chapter 337, Statutes of 2006) established the State Authorized Risk Assessment Tool for Sex Offenders (SARATSO) Review Committee to select the risk assessment tools for California. Currently, the identified tool for juveniles is the Juvenile Sexual Offense Recidivism Risk Assessment Tool II (J-SORRAT-II), and the tool for adults is the Static 99.

Per legal mandate a SARATSO score is required to determine level of supervision on parole, which may include global positioning system tracking. All SBTP youth must be evaluated prior to their release from DJJ and their score must be reported to both Parole and DOJ.

The following is the current DJJ procedure for reporting a youth's SARATSO score as required by Senate Bill 1128:

1. Either the J-SORRAT-II or Static 99 will be completed four (4) months prior to release from a DJJ facility for youth who are adjudicated for a sex offense requiring juvenile registration (PC 290.008). This score and the SARATSO and DOJ Information Sheet will be faxed to headquarters.
2. Some DJJ youth will not meet the criteria for either tool upon their release due to the coding rules of the assessment instruments. The J-SORRAT-II is **not** to be scored with youth over the age of 18 and the Static 99 is **only** to be scored with youth 18 and older, who committed their offense when they were 16 years or older.
3. If a youth does not meet the criteria for either tool, a SARATSO approved paragraph will be used to explain why an individual could not be given a risk assessment score. If a youth cannot be assessed through either tool, this paragraph will be faxed to headquarters in place of the score sheet.
4. All J-SORRAT-II and Static 99 scores will be tracked through headquarters on a monthly basis; headquarters will submit that information to DOJ in compliance with legal mandates. Scores sheets will be distributed to the unit, field and UHR files.

The following is taken from the SARATSO Policies and Procedures Manual, in an effort to clarify the mandated procedures for using these assessments under SB 1128:

1) Only officially trained persons can legally perform sex offender risk assessments in California using the SARATSO. The SARATSO Committee retains experts in the field of risk assessment who instruct persons from the various organizations. The persons trained by the experts to score the risk assessment instruments are known as the "super-trainers." Once a super-trainer is certified by SARATSO, he or she is authorized to train others to score the risk assessment instrument. The super-trainers must receive updated training by the experts on an on-going basis.

   Headquarters has a list of all those who were trained as "super trainers" and those trained by the "super trainers" in DJJ.

2) The super-trainer must use the authorized SARATSO curriculum to train within their agencies. The official Power Point presentation that must be used is available via e-mail from the SARATSO committee to certified super-trainers.

3) The SARATSO website has resources available for both the purposes of scoring the assessments and accessing forms related to both tools. This includes approved paragraphs to submit the score to the court and/or board or to explain why the person cannot be scored under the coding rules. To access the web site, go to www.dmh.ca.gov. Click on the link to "SARATSO" on the left side of the home page.

Assessments conducted by individuals who are not certified through the SARATSO approved curriculum and training will not meet the criteria outlined in SB 1128. SARATSO and DJJ are developing a monitoring system to ensure that all scores being submitted to DOJ meet the criteria of SB 1128.

The SARATSO committee continues to meet and alter procedures as problems are identified. DJJ will ensure that as new mandates are developed, DJJ procedures will reflect those demands and staff are fully made aware of the reason for any changes.

J. Training Requirements

Appropriate staff members involved with the SBTP will be trained regarding all pertinent aspects of the SBTP for their employment assignment. This will be accomplished through written policy, on-site, contract, and departmental expert training.

Appropriately, identified staff will be trained in the following areas:

- Psychological Assessment
- Group Counseling/Facilitation
- Welfare and Institutions Code 1800 Cases
- Case Management for Juvenile Sexual Offenders
- Developing Objective Treatment Goals
- Resource Groups
- Motivational Interviewing
- Understanding Trauma
- Attachment
- Brain-Based treatment

Staff will receive up to 40 hours of annual departmental training on SBTP. This includes training on the curriculum, testing, screening, family counseling, resource groups etc. Yearly training will also include providing days for SBTP Team Meetings.

Supplemental training will occur during individual unit weekly clinical meetings. Such training may include reviewing principles of MI or CBT, review of risk assessments, overview of new research, case management or group facilitation.

The SBTP Coordinator helps plan, coordinate training and administers the training budget.

1. Orientation Training

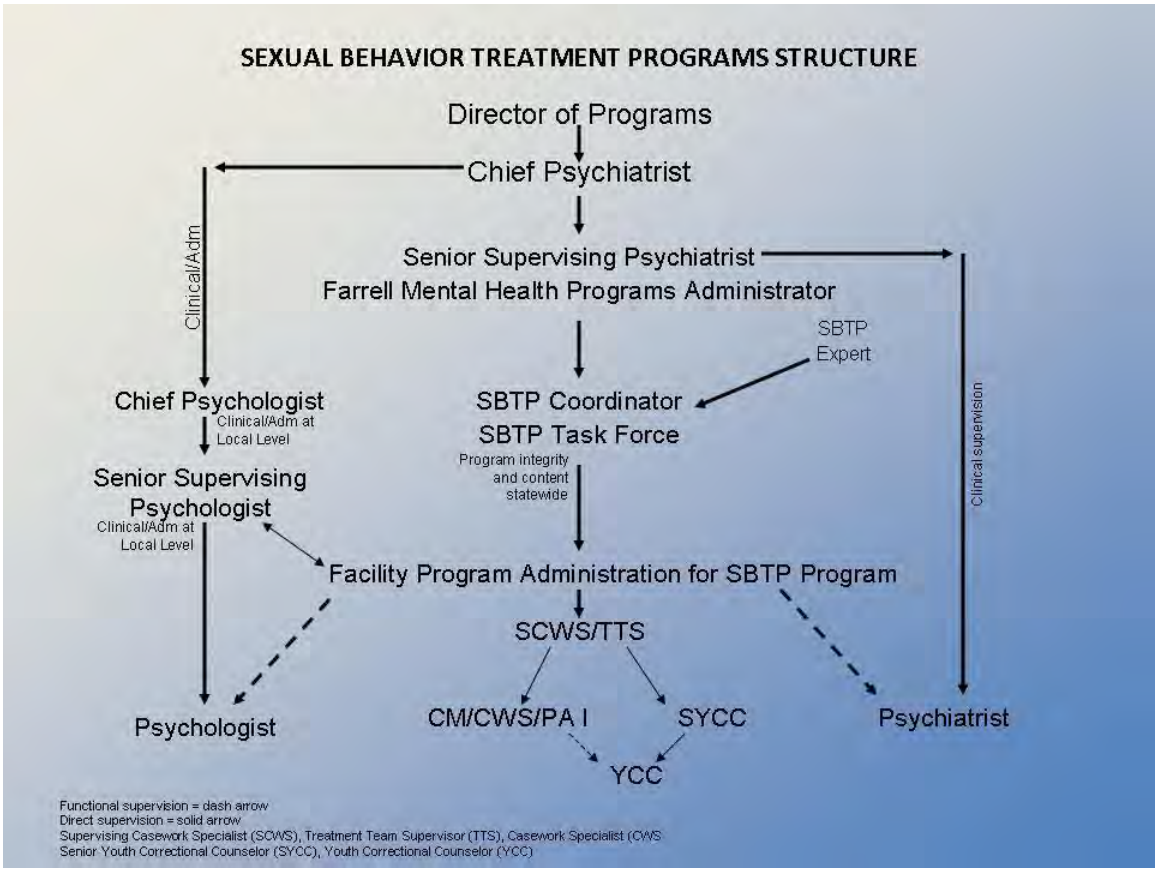
Upon assignment to an SBTP unit, staff will participate in an orientation period not to exceed 1 month prior to receiving an individual caseload.

- YCC staff will shadow an experienced SBTP YCC during groups, individual sessions and case conferences.
- Clinical staff will shadow an experienced SBTP psychologist during group, individual and family sessions and case conferences.

If, due to a facility re-bid, a number of new staff will be assigned to the SBTP unit at the same time, an orientation period will not occur. The SBTP Coordinator will be informed when a facility re-bid is scheduled and will then schedule an SBTP specific training to occur shortly after the new staff are assigned to the SBTP. This will ensure newly assigned staff have the resources to provide appropriate SBTP treatment.

IV. Sexual Behavior Treatment Program Organizational Structure

A. SBTP Organizational Chart[18]



1. Director of Programs: Reports to the directors of DJJ
Supervises the Chief Psychiatrist

Duties: Manages all DJJ programs and ensures program integrity.

2. Chief Psychiatrist: Reports to Director of Programs
Supervises Senior Supervising Psychiatrist and Chief Psychologists

Duties:

1) In a diagnostic or outpatient clinic the chief psychiatrist plans and directs the preventive and corrective general medical and psychiatric work with each offender; or

2) Plans and directs the psychiatric and mental health services program in a correctional facility; or

[18] SCWS: Supervising Casework Specialist, TTS: Treatment Team Supervisor, CM: Case Manager, CWS: Casework Specialist, PA 1: Parole Agent 1, SYCC: Senior Youth Correctional Counselor, YCC: Youth Correctional Counselor

3) In headquarters, has statewide responsibility for the DJJ's mental health program in such areas as program development, planning, standards and evaluation. Maintains order and supervises the conduct of inmates; protects and maintains the safety of persons and property.

3. Senior Supervising Psychiatrist: Reports to Chief Psychiatrist
Supervises psychiatrists and SBTP Coordinator

Duties: Under general direction, supervise physicians and other professional personnel giving psychiatric care to mentally ill patients; gives psychiatric services to such patients.

4. Chief Psychologists: Reports to Chief Psychiatrist
Supervises Senior Supervising Psychologist
Working relationship with SBTP Coordinator

Duties: Responsible for the overall supervision of psychologists in a correctional facility. As supervisor of psychological services, plans, directs and coordinates the various psychological activities consistent with the mission of a particular correctional facility. Responsible for maintaining order and supervising the conduct of incarcerated youth and to protect and maintain the safety of persons and property.

5. Senior Psychologist Supervisor: Reports to Chief Psychologist
Supervises Psychologists
Working relationship with SBTP Coordinator and Program Administrator

Duties: Perform difficult and responsible assignments relating to:

a) Psychological assessment and treatment and either,

b) Assists in the direction of the psychology program of a health facility, or

c) Plans, organizes, develops and directs a psychology program similar in size and nature at a health facility; or

d) Plans, organizes and coordinates a special patient treatment program, which uses psychological techniques as its main non-medical emphasis at a health facility, and

e) Coordinates the work of treatment staff of various clinical specialties and volunteers in the program.

In addition, as needed, will serve as a department wide expert and psychology consultant in a specific psychology discipline; maintain order and supervise the conduct of youth; protect and maintain the safety of persons and property.

6. Psychologist: Reports to Senior Psychologist
Working relationship with Program Administrator and SYCC, CM / CWS / PA 1, YCC

Duties: Carry out difficult assignments in clinical psychology, which involve the assessment and treatment of juveniles, program development and evaluation, clinical research, professional training and consultation. Maintain order and supervise the conduct of youth; protect and maintain the safety of persons and property.

7. SBTP Coordinator: Reports to Senior Supervising Psychiatrist
Supervises SBTP Taskforce
Working relationship with Chief Psychologist, Senior Psychologist, Program Administrator and Superintendent

Duties: 1) Perform difficult and responsible assignments relating to psychological assessment and treatment and assist in the direction of the SBTP programs and; 2) plan, organize and coordinate the SBTP programs, and coordinate the work of treatment staff of various clinical specialties and volunteers in the program. In addition, determine program placement for SBTP youth in statewide SBTP programs.

8. Facility Program Administrator: Reports to Superintendent
Supervises SCWS / TTS
Working relationship with SBTP Coordinator and Senior Psychologist

Duties: Responsible for the administration of a DJJ camp/facility; establishes policy for and directs the overall planning, organizing, and evaluating of all care and treatment, custody and security, safety and discipline, education, feeding, recreation and forestry work programs and medical services for the youthful offenders.

9. SCWS / TTS: Reports to Program Administrator
Supervises CM / CWS / PA 1 and SYCC
Working relationship with Senior Psychologist

TTS duties while at the facility:

1) Plans, organizes, and directs a program for the care, treatment, custody, supervision, and discipline of youthful offenders for two or more treatment teams; and/or supervises, coordinates, and monitors the Ward Rights Program;
2) Serves as the assistant superintendent in a youth conservation camp, operated as a joint venture with the Department of Forestry and Fire Protection; or
3) Serves as the assistant administrator in the Youth Authority Training Center.

SCWS duties: Provide first line supervision to Casework Specialists working with youth in a DJJ facility; assist in planning, organizing, and directing the casework program; maintain order and supervise the conduct of youth and residents; protect and maintain the safety of persons and property.

10. CM / CWS / PA I: Reports to SCWS/TTS
Working relationship with YCC
Working relationship with Psychologist

PA I duties: 1) Supervise a caseload of youth on parole; or 2) interview and counsel youth in DJJ institutions and camps and collect and evaluate information and make recommendations necessary for the ward's rehabilitation; provide functional casework supervision to the treatment team staff in a living unit(s) or camps.

CWS duties: Provide specialized casework, clinical, diagnostic, and intensive treatment services for wards and residents; maintain order and supervise the conduct of wards and residents; provide functional casework supervision to the treatment team staff; protect and maintain the safety of persons and property.

CM duties: Similar to PA I, however this job descriptionis still being developed; official DPA job specifications have not been developed/released.

11. SYCC: Reports to SCWS / TTS
Supervises YCC
Working relationship with psychologists

Duties: 1) In a facility, plan, organize, supervise, and direct the work of employees responsible for the counseling, supervision, and custody of youthful offenders; in directly responsible for carrying out a planned counseling program on a living unit; or 2) in the Youth Authority Training Center trains and supervises entry-level peace officers.

12. YCC: Reports to SYCC
Working relationship with CM / CWS / PA 1, Psychologist and Psychiatrist

Duties: Responsible and accountable for the counseling, supervision and custody of an assigned group of youthful offenders; analyzes, organizes and records casework information necessary for treatment and parole planning.

13. Psychiatrist: Reports to Senior Supervising Psychiatrist
Working relationship with Psychologist, Program Administrator and YCC / SCWS / TTA / CWS

Duties: Provide psychiatric services to youths in DJJ facilities, including psychotropic medication. Assist in treatment planning and assess appropriate level of care.

B. Sex Behavior Treatment Program (SBTP) Administrative Task Force

The SBTP Administrative Task Force is a mechanism to allow for changes in the SBTP programs while still maintaining standardization between the different units. This is a particularly important aspect in treating youth with sexual abuse behaviors as it is a dynamic field and therefore new research will modify or inform as to best practices and empirically driven Individual Treatment Plans. Allowing a variety of classifications a voice during taskforce meetings ensures decisions will be made in service of the youth, the Interdisciplinary Team and overall integrity of the SBTP program while also allowing a forum to dialog about what is working and develop solutions to what is not working.

Members will include the SBTP Coordinator, SBTP Research Program Specialist, a Program Administrator from each SBTP site, a Senior Psychologist Supervisor from each facility who supervises psychologists working on the SBTP units, a member from education (this individual could be located at Headquarters), a member from policy division and two members from Field Parole (1 North and 1 South).

The SBTP Administrative Task Force will meet quarterly. Their focus will be on developing and reviewing the implementation of the SBTP Remedial Plan and ensuring compliance with the new expectations related to the program and curriculum. They will dialog about how each program is transitioning with the changes and develop solutions to problems that arise during implementation.

The SBTP Administrative Task Force will continue to maintain up to date knowledge of juvenile SBTP treatment and propose changes to the program and curriculum in order to maintain best practices. Therefore, no changes will be made to program structure or curriculum on an individual program, prior to being given approval by the SBTP Administrative Task Force.

The SBTP Administrative Task Force will also meet as needed to review special cases referred for placement on the SBTP unit.

1. SBTP Workgroup

The SBTP Workgroup is a group that will be developed at the request of the Administrative Task Force when completion of a project or program modification is needed. Membership in this workgroup will be specifically related to a project developed by the SBTP Administrative Task Force, and therefore this group will have revolving memberships. This group will meet, as needed and as determined by the timeframes of the particular project. The SBTP Workgroup's focus will be the development of curriculum, conducting pilot programs at individual sites and conducting training on specific SBTP issues for all SBTP staff. Primarily they are tasked to accomplish the groundwork behind the SBTP program. The specific group will be disbanded as the project is concluded.

C. Staffing

1. Headquarters

- Senior Psychologist Supervisor/Sexual Behavior Treatment Coordinator
- Research Program Specialist
- Office Technician
- SBTP Administrative Task Force

2. Sexual Behavior Treatment Program Team Positions

- Program Administrator
- Senior Psychologist Supervisor
- Clinical Psychologist
- Supervising Casework Specialist
- Senior Youth Correctional Counselor
- Case Manager
- Re-Entry Parole Agent
- Youth Correctional Counselor
- Youth Correctional Officer
- Office Technician
- Compliance Team

The Sexual Behavior Treatment Program will have the following staff assigned with a maximum of 36 youth per living unit:

- Two Clinical Psychologists
- One Treatment Team Supervisor or equivalent
- One Casework Specialist
- One Senior Youth Correctional Counselor
- Two Youth Correctional Counselors on the second watch
- Three Youth Correctional Counselors on the third watch
- One Youth Correctional Officer on the first watch

D. Supervision

Treating youth with sexually abusive behavior evokes numerous feelings, including anger, frustration, anxiety, sympathy and affection. Good supervision is essential in dealing with these intense feelings and thoughts. (Performance-based Standards for

Youth Correction and Detention Facilities a Resource Guide: Sex Offender Programming in Youth Correction and Detention Facilities.)

The SBTP will provide the following supervision for treatment staff related to vicarious trauma:

- The Senior Psychologist Supervisor will clinically supervise SBTP psychologists. Supervision sessions will focus on reviewing cases and discussing vicarious trauma[19] and counter-transference[20] related to working with a SBTP population.
- Weekly Team Meetings will include discussing difficult cases and issues related to vicarious trauma. This will be documented in the Weekly Team Meeting minutes and kept in a binder on each SBTP unit.
- Yearly training will occur and will focus on vicarious trauma and issues related to treating youth with sexually abusive behavior.
- Psychologists and YCCs will use casework time to discuss issues related to vicarious trauma and counter-transference specific to their caseload.

The SBTP will provide the following treatment supervision:

- Peer review of clinical notes and documentation
- Case note review conducted by TTS or SCWS
- Weekly Team Meetings to discuss specific cases and current Individual Treatment Plans

[19] Vicarious traumatization (VT) is defined as the negative transformation in the self of the helper that comes about because of empathic engagement with survivors' trauma material and a sense of responsibility or commitment to help (Risking Connection; Saakvitne, Gamble, Pearlman, & Lev, 2000).

[20] **counter transference** - the psychoanalyst's displacement of emotion onto the patient or more generally the psychoanalyst's emotional involvement in the therapeutic interaction

V. Sexual Behavior Treatment Program Resource Material

A. Parole Board Resource Guide

The Parole Board Resource Guide provides information to the Juvenile Parole Board (JPB) regarding current research in SBTP treatment, information related to risk assessment and areas that should be considered when evaluating progress in treatment and readiness for release.

The Parole Board Resource Guide provides the following information to the JPB:

- Summary of current research in the area of juveniles who sexually abuse
- Definition of sexual offenses and juvenile sex offense typologies
- Risk assessment
- Overview of SBTP
- Placement decisions
- Summary of SBTP documentation

In order to ensure that the Parole Board Resource Guide remains up to date and relevant for the Board Members, the SBTP Administrative Task Force will update the Parole Board Resource Guide every 2 years or as appropriate, based on program changes.

B. SBTP Staff Orientation Packet

Staff assigned to the SBTP will receive an Orientation Packet that will introduce the SBTP and treatment of youth with sexually abusive behavior. The SBTP Staff Orientation Packet will include the following:

- Overview of SBTP program structure and curriculum
- Overview of current research on treating youth with sexually abusive behavior
- Overview of interventions and treatment approaches that are effective with a SBTP population
- Resource guide of materials

In order to ensure that the SBTP Staff Orientation Packet remains up to date and relevant for staff, the SBTP Administrative Task Force will update the Parole Board Resource Guide every year or as appropriate based on program changes.

C. SBTP Youth Orientation Packet

Youth assigned to the SBTP will receive an Orientation Packet that will introduce the SBTP and expectations of the program. The SBTP Youth Orientation Packet will include the following as well as information specific to their facility:

- Overview of SBTP program structure and curriculum
- Confidentiality form
- Program rules and guidelines
- Suspension criteria
- Exit criteria

In order to ensure that the SBTP Youth Orientation Packet remains up to date and relevant for youth, the SBTP Administrative Task Force will update the SBTP Youth Orientation Packet every year or as appropriate based on program changes.

VI. Adjunct Treatment Services

As described in the Continuum of Care section in the previous pages, all youth are screened for mental and physical health issues upon arrival, intermittently during their stays, and prior to reentry to parole. The services available for physical health, mental health and substance abuse, combined with the Sex Offender treatments offered, continue to be made available to youth as they transition out to parole. Below are some of the other services offered in support of the youth in facilities and those leaving the confines of DJJ.

A. Psychopharmacological Treatment

All DJJ psychiatrists and physicians prescribing a psychopharmacologic agent and/or a course of psychopharmacologic treatment will work within these guidelines and the current standards of practice in the national psychiatric and correctional community.

The psychiatrist has the authority and responsibility for decisions about the choice of a psychopharmacologic agent and/or course of pharmacologic treatment, the route and schedule of administration, the dosage and duration and for the integration of psychopharmacologic treatment within the total treatment plan.

If a psychopharmacologic agent or a course of psychopharmacologic treatment is prescribed, the youth's mental and physical developmental stage will first be considered.

Youth between the ages of 12 to 14 will be evaluated and treated by a board certified or board eligible Child Psychiatrist whenever possible. If a Child Psychiatrist is not on site, a General Psychiatrist may prescribe psychopharmacologic agents and/or course of psychopharmacologic treatment after telephone consultation with a DJJ Child Psychiatrist at another facility, the Senior Supervising Psychiatrist or the Chief Psychiatrist.

B. Education Services

The California Education Authority (CEA), correctional school district of DJJ, operates six comprehensive high schools and two fire camps. All high schools located within juvenile facilities, are accredited by the Western Association of Schools and Colleges and all courses of study meet the *Content Standards for California Public Schools* adopted by the State Board of Education. In addition, students are given the opportunity to participate in career-vocational training and post-secondary studies. The mission of the CEA is to empower each student to become a civil, responsible, employable and knowledgeable lifelong learner. All non-high school graduate students in the care of the DJJ have a High School Graduation Plan and are required to participate in a High School program leading to a High School Diploma or its equivalency. A key goal for the CEA is to prepare students to transition successfully to the community upon release from DJJ.

C. Medical Services

All youth within DJJ are provided a full array of clinically necessary medical services, including dental and mental health.

VII. Policies Affecting the Sexual Behavior Treatment Program

The SBTP will follow all DJJ policies as they related to serving all DJJ youth. The following policies listed are those that directly affect SBTP youth.

A. Confidentiality and Notification of Rights

Currently being written and will include the following:

- DJJ policy on Confidentiality and Notification of Rights
- Wording that deals specifically with SBTP youth
- Standardized forms that will be given to DJJ youth
- Standardized forms that will be given to families involved in family sessions

Once completed and approved, aspects of this policy will be included in this section of the guide.

B. Welfare and Institutions Code 1800

The following is taken from the I&C Manual for Forensic Evaluation Welfare and Institutions Code (WIC) 1800/1800.5.

If DJJ determines, through its Chief Deputy Secretary (CDS) or designee, that at the time of the current WIC 1800 evaluation the youth has a currently diagnosed mental or physical deficiency, disorder or abnormality that causes the youth to have serious difficulty controlling his or her behavior such that the youth would be physically dangerous to the public if discharged, then DJJ shall make a request to the District Attorney (DA) of the county of commitment to file a petition to the committing court for an order directing that the youth remain subject to the control of the DJJ. The petition shall be filed by the DA at least 90 calendar days before the DJJ Available Confinement Time or jurisdiction expires.

If the decision is made at any level not to proceed with a WIC 1800 petition, the JPB under WIC 1800.5 may request the CDS to review the case for further action. The CDS shall designate a psychiatrist or psychologist to review the case and thereafter affirm the finding or order additional assessment of the youth. Any JPB request under WIC 1800.5 shall be submitted to the CDS not less than 120 days before the date of final release.

If, after review, the psychiatrist or psychologist affirms the initial finding, concludes that a subsequent assessment does not demonstrate that a youth is subject to extended confinement pursuant to WIC 1800, or fails to respond to a request from the JPB within 15 calendar days, and the JPB continues to find that at the time of the current WIC 1800 evaluation the youth has a currently diagnosed mental or physical deficiency, disorder or abnormality that causes the youth to have serious difficulty controlling his or her behavior such that the youth would be physically dangerous to the public if discharged,

then the JPB may request the prosecuting attorney to petition the committing court for an order for a WIC 1800 time extension.

Please refer to the Forensic Evaluation -- Welfare and Institutions Code 1800/1800.5 policy, Section 3320 for the following details:

- Definitions
- Training
- Quality Assurance
- Procedures
- Forms

C. Program Service Day

Program Service Day (PSD) was developed to ensure that all DJJ facilities follow a local schedule for youth programming in an effort to ensure youth remain in school during the day, while having access to medical care and treatment services. All youth activity must fit within the local PSD schedule, including SBTP groups, individual and family sessions.

Tracking procedures in WIN will ensure that a youth will not be scheduled for activities during the same time in the day. WIN will also track and monitor that 40-70% of a youth's time is being spent on structured activities.

The following information is taken from The Program Service Day Policy (I&C Section 5600 & ES Section 3266) that outlines the Local Procedures each facility must follow.

1. A coordinated and collaborative effort with meetings and input from medical, mental health, education and facility staff is used to implement the PSD schedule facility-wide.
2. Facilities will review reports regarding services being met.
3. Facilities will develop and implement strategies for improvement, if standards are not met.
4. A collaborative effort between living unit, security, medical, education and mental health staff will develop living unit/facility schedules. Facilities will ensure a living unit/facility schedule that depicts structured activities for all waking hours for youth before, during, after school in the evenings and on weekends.
5. Facilities will ensure a school enrollment schedule depicting courses needed by each youth to meet education requirements including courses to graduate or obtain a GED.
6. Describe how the schedule depicting treatment/rehabilitation interventions was developed for the treatment period Mon-Fri during school hours. Facilities will ensure a schedule depicting treatment/rehabilitation interventions that will be offered during the school day. If the interventions are held in the school area, a copy of the schedule will be provided to the School Scheduler so that each youth can be scheduled into the requested treatment/rehabilitative intervention periods.

7. Describe how the living unit/facility schedule with back up staff was developed. Facilities will ensure a living unit/facility schedule depicting staff assignments for treatment rehabilitative interventions from all areas to include a list of "back up staff" to cover the intervention periods scheduled during the school day (similar to substitute teachers).

D. Sexual Misconduct Policy

DJJ does not tolerate youth sexual misconduct. The Sexual Misconduct Policy addresses six categories of sexual misconduct, which include five categories of serious sexual misconduct and one category of non-threatening sexual misconduct.

Serious Sexual Misconduct includes:

- Making body contact of a sexual nature, not including battery
- Exposure of genitals
- Masturbation with exposure
- Intentionally sustained masturbation without exposure
- Making a verbal epithet, written comment, or gesture of a sexual nature

All DJJ employees will document a youth engaging in serious misconduct on a Level 3 Serious Misconduct Behavior Report (DJJ 8.403 B)

Non-threatening Sexual Misconduct includes:

- Possessing or displaying a sexually explicit image or obscene material

All DJJ employees will document a youth engaging in such an incident on a Level 3 Intermediate Misconduct Behavior Report (DJJ 8.403 A)

A Mental Health Referral (DJJ 8.039) is submitted when a youth exhibits any of the following four serious sexual misconduct behaviors:

- Making body contact of a sexual nature, not including battery
- Exposure of genitals
- Masturbation with exposure
- Intentionally sustained masturbation without exposure

Within 3 working days after the Mental Health Referral is assigned a psychologist will do the following?

- Evaluates and interviews the youth face to face
- Reviews the UHR and Field File

- Determines if youth needs to be considered for Healthy Living Treatment and or Residential/Individualized treatment
- Offers additional treatment if youth is already assigned to a residential SBTP
- Refers to Behavior Report or contacts reporting employee as necessary
- Documents any findings in the chronological notes contained in the UHR and in WIN
- Communicates to the assigned parole agent/casework specialist and treatment team if recommending any changes to existing treatment plan
- The SBTP Coordinator will be contacted if SBTP treatment is recommended in order to place youth in appropriate SBTP treatment

VIII. Quality Assurance

The SBTP will adhere to the policies and procedures of the Youth Programs/Services Criteria and Protocol. The overall objective of program monitoring and performance measurement is to track and monitor the target population from identification through parole performance and measure the outcome of sex offender programming. The evaluation process includes a review of program elements, a description of the implementation process and a description of data points used to assess program success and failure.

Historically speaking, rigorous scientific and statistical research and evaluation studies on recidivism have been difficult to do in juvenile sex offender populations. Due to the low incidence numbers, low rates of reoffending, and the idiosyncratic nature of sex offenses in general, there is very little in the way of research in reporting of positive and effective outcomes of treatments of youthful sex offenders.

1. "The following, more detailed and system-related criteria are presented for utilization in evaluating and managing sex offender treatment practices throughout juvenile correctional system:" (Performance-based Standards for Youth Correction and Detention Facilities: A Resource Guide Sex Offender Program in Youth Correction and Detention Facilities.)
2. A continuum of programs and services are available to meet the heterogeneous needs of juvenile sex offenders. A range of programming, from intensive residential to outpatient services matches the risk levels of youth to treatment needs and incorporates programming to deal with presenting co-morbid problems, i.e., developmental disabilities, substance abuse, and mental illness.
3. A mission statement and philosophy of treatment are clearly documented and effectively communicated to all staff in such a way that all practices are guided by the mission statement and underlying philosophy.
4. A sex offender typology distinguishes the varying clinical and criminal characteristics and dimensions of youth committed for sexual offenses through the correctional system.
5. Each youth undergoes a literature driven sex offender specific assessment upon entering the correctional system, including an assessment of risk, social attitude and beliefs, sexual attitudes and interests, and general psychological functioning.
6. Differential classification procedures ensure that programmatic services meet the individual and special needs of each youth.
7. A comprehensive treatment planning process ensures that an ITP is developed and written for each youth. This process includes systematic and periodic reviews to monitor, update, and modify the treatment plans wherever indicated.
8. Major program goals and objectives are documented and are fully consonant with the mission statement and philosophy of treatment.
9. Well-defined criteria are documented for determining successful program completion, program suspension, and program re-entry and program termination.
10. Program environments are appropriately structured to support and maintain healthy peer cultures in which youth can learn, grow and practice new and responsible behaviors and relationships.

11. Correctional staff and treatment personnel are organized into functional units or teams that implement a seamless set of custodial, security, and treatment interventions to direct and monitor youths' daily living practices, behavior, relationships, and program involvement.

12. A behavioral management system is documented, implemented and understood by all staff and youth, ensuring that responsible behavior and positive, respectful relationships are recognized and reinforced, while irresponsible behaviors are managed and corrected.

13. A schedule of all daily activities includes all elements of required behavior, e.g., personal hygiene, education, recreation, treatment. Time spent in each activity reflects the value of the activity in the philosophy of treatment.

14. Treatment components, therapeutic modalities, and programmatic activities and interventions are designed and implemented to support each youth in meeting the program's expectation and achieving the goals and objectives delineated in Individual Treatment Plans.

15. Transitional and reentry programming and services are central components of sex offender treatment, insisting upon collaborative efforts between institutional personnel, probation and parole personnel, families, and community-based service providers. Such collaborative efforts begin when each youth enters the correctional system to enhance assessment, treatment planning, sex offender treatment and community re-integration.

16. A comprehensive training plan is designed and implemented to ensure that all staff are equipped with the requisite knowledge and skills to manage and treat juvenile sex offenders. Training reflects the philosophy of treatment and includes all staff who works with the youth.

17. An offender tracking system maintains a database, compiling, at minimum, demographic information, youth movement through the correctional system and sex offender programs and projected release dates.

18. Program monitoring and quality assurance plans and procedures ensure that prescribed policies and practices are delivered as planned.

A. Standards of Care

Currently, no mandated standards of care have been adopted for the treatment of youth who sexually abuse; however, there are guidelines and recommendations regarding approaches and treatment components that should be included in SBTP programs. These include (Rich, 2008)[21]:

- Individualized approach to the treatment of each youth, without reliance on workbook and relapse prevention materials, although these materials should be included and folded into treatment.
- On an individualized basis, targeting of behavioral and emotional symptoms that are directly and indirectly related to treatment.

[21] Dr. Phil Rich, Ed.D., MSW, LICSW, DCSW, AFSW; Clinical Director; Stetson School; leading clinician and author in treating juvenile sex offenders. List sent to Ian Curley, National Council of Juvenile and Family Court Judges, forwarded to DJJ staff Barbara Mendenhall on 9/8/08.

- Treatment length specific to different youth and their needs, but at least 10 months and as long as 2 years.
- Treatment based on a structured assessment of risk and guided by a re-assessment of risk over time and especially the treatment of dynamic risk factors.
- Treatment aimed, at least in part, on the development of protective factors.
- Multiple therapy groups run by clinicians trained in sexually abusive behavior, covering a range of topics specific to sexually abusive behavior.
- Individual therapy at least once a week, addressing direct and indirect correlates of the sexually abusive behavior.
- Family treatment aimed at understanding the family, building strengths, and recognizing and working to change problematic family structures, relationships, and communication.
- Medication for psychiatric symptoms, without over-reliance on medication.
- Recognition and remediation of educational problems.
- Recreational skill building.
- Development of self-regulatory and social skills.

B. Compliance

Compliance monitoring is the process of assessing whether standards, procedures and rules are being conducted as stated in the Program Guide.

Compliance monitoring for the SBTP will be conducted using the SBTP Audit Tool accepted by the courts in accordance with the SBTP Remedial Plan. The SBTP Audit Tool outlines each item that is to be evaluated and the proof of practice for this item, which includes WIN file reviews, unit file review and UHR file reviews.

C. Quality Assurance Measures

The SBTP will adhere to DJJ's Programs Policy that outlines specific quality assurance indicators for all DJJ programs. Language will be included in the SBTP guide as that policy is completed and approved.

SBTP will specifically monitor the following as it relates to Quality Assurance:

- SBTP assessment
- Individual treatment planning
- Treatment programming
- Incentives, specific to SBTP
- Family involvement and reentry

Performance Measures specific to SBTP Include:

- Entrance and exit criteria
- Program completion
- SBTP curriculum completion

A detailed Quality Assurance manual will be created to detail all aspects surrounding compliance and Quality Assurance. These details will be finalized through the development of the curriculum and implementation plan.

IX. Program Guide Procedures

A. Maintenance of the SBTP Program Guide

The SBTP Coordinator will maintain the SBTP Program Guide by:

- Monitoring each SBTP unit to ensure adherence to the guide.
- Ensure staff have resources to comply with requirements of guide.
- Review data collected through compliance and quality assurance measures.
- Work with the Administrative Task Force to update and modify program based on data collected through compliance and quality assurance measures.

B. Updating the SBTP Program Guide

The SBTP Coordinator and Administrative Task Force will be responsible for updating the SBTP Program Guide:

- The SBTP Program Guide will be reviewed yearly to determine if updates are needed.
- Based on the modifications needed, a SBTP work group may be used to complete the SBTP Program Guide Update.
- Statewide training will be developed and conducted to ensure changes made to the Program Guide are implemented in a standardized fashion.
- The SBTP Coordinator will coordinate all trainings related to modifications of the Program Guide.

Appendices

A. Forms

1. Treatment Contract w/ signatures for all members of the treatment team
2. Treatment refusal
3. Referral to SBTP program for youth with no 727.6 criteria and/or adjudication/conviction of a sexual offense
4. Individualized Treatment Plan (Risk/Needs/Safety Assessment) template
5. SBTP Parent Assessment Form
6. SBTP Family Counseling Update Form
7. Treatment Hour Override Form
8. SARATSO and DOJ Information Form
9. SARATSO approved templates

B. Parole Board Resource Guide

C. SBTP Staff Orientation Packet

D. SARATSO Policies and Procedures Manual

E. Juvenile Sex Offense Specific Treatment Needs and Progress Scale

F. Glossary / Acronyms

G. References

Appendix A
Forms

Appendix B
Parole Board Resource Guide

The SBTP program in the Department of Juvenile Justice is committed to providing treatment that is focused on not creating more victims and thereby committed to ensuring public safety. The SBTP treatment is developed from research showing techniques and areas of focus that will help promote public safety and reduce the risk to reoffend. The following Guide will provide a reference to the DJJ Parole Board to help provide a structure for determining progress and treatment and identify areas of high risk for this population.

A. Summary of Current Research in the area of Juveniles who Sexually Abuse

1. Juvenile Development
2. How Trauma Affects Development
3. Juvenile Offenders
4. Juvenile Sex Offenders

B. Definition of Sexual Offenses and Juvenile Sex Offense Typologies

1. Healthy vs. Unhealthy
2. Sexually Reactive
3. Statutory Rape
4. Pedophilia

C.

D. Risk Assessment
1. What is a risk assessment
2. Static vs. dynamic risk factors
3. Assessing risk with a juvenile population
4. SARATSO Tools

E. DJJ SBTP Program
1. Healthy Living
2. SBTP Program
3. SBTP Curriculum
4. SBTP Individualized Treatment Plans

F. Placement Decisions

1. Transition (group home vs. family home)
2. Monitor and GPS considerations
3. Family Contact
4. Family Reunification
5. Types of Treatment in the Community (should all youth go.)

G. Summary of Reports and Information

Appendix C
SBTP Staff Orientation Packet

Appendix D
SARATSO Policies and Procedures Manual

Appendix E
Juvenile Sex Offense Specific Treatment Needs and Progress Scale

Appendix F
Glossary / Acronyms

Acronym	Definition
BTP	Behavioral Treatment Program
Ca-YASI	California Youth Assessment Screening Instrument
CBT	Cognitive Behavior Treatment
CDS	Chief Deputy Secretary
CM	Case Manager
CWS	Casework Specialist
DBT	Dialectical Behavioral Therapy
DDM	Disciplinary Decision Making System
DJJ	Division of Juvenile Justice
DOJ	Department of Justice
GPS	Global positioning system
IBTP	Intensive Behavior Treatment Program
I & C	Institutions and Camps
ICR	Initial case review
ITP	Individualized Treatment Plan
JJAC	Juvenile Justice Administration Committee
JPB	Juvenile Parole Board
J-SOAP II	Juvenile Sex Offender Assessment Protocol
J-SORRAT-II	Juvenile Sexual Offense Recidivism Risk Assessment Tool II
MI	Motivational interviewing
OVSRS	Office of Victim and Survivor Rights and Services
PBD	Projected Board Date
PC	Penal Code
SARATSO	State Authorized Risk Assessment Tool for Sex Offenders
SB	Senate Bill
SBTP	Sexual Behavior Treatment Program
SCP	Specialized Counseling Program
SCWS	Senior Casework Specialist
SYCC	Senior Youth Correctional Counselor
TTS	Treatment Team Specialist
WIC	Welfare and Institutions Code
WIN	Ward Information Network
YCC	Youth Correctional Counselor

Appendix G
References