

Safe and Effective Intervention and Management Approaches for Juvenile Sex Offenders and Youth with Sexually Abusive Behavior

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I - Introduction

Juvenile sex offenders and youth with sexually abusive behavior are a growing national concern. While the field continues to make advances, there is still much more work needed to keep our communities safe, address the needs of victims and their families, and provide effective interventions for juveniles with sexually abusive behavior and their families. Current evidence-based and promising practice treatment programs emphasize collaborative efforts and strategies which consist of legal sanctions, monitoring strategies, and specialized clinical programming.

Seeking to improve Ohio's ability to safely manage and treat juvenile sex offenders and youth with sexually abusive behavior, the Ohio Association of Child Caring Agencies (OACCA), a statewide association of private and public agencies that provide a wide array of services to thousands of children and families annually, researched and began to develop a set of standards for programs that serve juvenile sex offenders and youth with sexually abusive behavior. After a year of effort, OACCA was joined by the Ohio Department of Youth Services who applied for and received a grant award under the *2005 Comprehensive Approaches to Sex Offender Management Grant Program*, sponsored by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA). As one of only nine jurisdictions awarded nationally, Ohio has a unique opportunity to contribute to ongoing efforts to create and implement effective solutions in the management of youth with sexually abusive behavior.

Ohio's grant design supports a two-phased effort. Phase I focuses on a thorough review of Ohio's juvenile sex offenders and youth with sexually abusive behavior management policies and practices based upon developing empirical knowledge and emerging national practices. This activity is being undertaken by an established Advisory Committee and provides a forum to examine actual practice within Ohio, and to identify the critical gaps in the systems. The Advisory Committee determined that for this target population:

- Consistent standards for assessment and treatment do not exist;
- Standards for treatment/service providers do not exist;
- There is no identified continuum of treatment services;
- Ohio does not utilize a statewide multidisciplinary team to facilitate safe and successful re-entry into the community;
- There is no collaborative case planning process; and,
- Recently enacted juvenile registration and notification laws have resulted in labeling juveniles, impacting placement options and creating barriers to successful re-entry by limiting access to living arrangements, education and employment.

The Advisory Committee now is in the process of developing a strategic plan for the safe and effective management of juvenile sex offenders and youth with sexually abusive behavior capitalizing upon evidence-based management and treatment practices, while targeting critical concerns. This plan will be submitted to Bureau of Justice Assistance and once approved, Phase II, the implementation of the plan activities will be initiated.

Two core values drove the work of the Advisory Committee. First and foremost is safety, community safety and the safety of the victims and their families. Second are the needs and best interests of juvenile sex offenders and youth with sexually abusive behavior and their families. The Committee worked to validate, balance and honor the interests of community, victims, families and juveniles.

In addition to these two core values, the Advisory Committee identified four elements necessary to develop safe and effective intervention and management approaches for juvenile sex offenders and youth with sexually abusive behavior. These four elements serve as the foundation for Phase II of Ohio's strategic plan and include:

1. The creation and implementation of consistent standards regarding:
 - Assessment;
 - Treatment;
 - Supervision, Transition and Re-entry; and,
 - Service Provider Qualifications.

2. The construction and implementation of a system map which identifies the decision points and guides the movement of juvenile sex offenders and youth with sexually abusive behaviors through our community systems. The system map delineates:
 - Decision points in the process and who is responsible;
 - Recommended periods of time it takes to move from one point in the system to the next;
 - Collaborative case planning processes; and,
 - Multidisciplinary team activities to facilitate safe and successful re-entry into the community.

3. The development of community education training modules which focus on:
 - Dispelling the common myths regarding juvenile sex offenders and youth with sexually abusive behavior and their victims with research and professional experience;
 - Dispelling unwarranted fears with sound information and self-protection strategies; and,

- Familiarizing Ohio's citizens with the resources and activities available to support community safety.
4. The establishment of a Sex Offender Management Board – Juvenile Division to:
- Adopt and enforce program standards for the treatment of juvenile sex offenders and youth with sexually abusive behaviors;
 - Adopt and prescribe a standardized procedure for the assessment, evaluation and identification of juvenile sex offenders and youth with sexually abusive behaviors;
 - Analyze the effectiveness of the assessment, identification, and treatment procedures and programs developed for juvenile sex offenders and youth with sexually abusive behaviors;
 - Research and approve a risk assessment screening instrument;
 - Implement, monitor and evaluate service provider and staff qualifications
 - Remain current on emerging research and legal requirements and recommend modifications to standards, system map and community education modules based on an improved understanding of the issues.

These elements recognize that juvenile sex offenders and youth with sexually abusive behavior have multiple needs spanning a variety of services, agencies and systems. The responsibility for effective management of juvenile sex offenders and youth with sexually abusive behavior does not rest with one agency or solely with the criminal justice system. These elements reflect a continuum of juvenile justice and clinically-based responses and interventions emphasizing community safety and victim awareness.

For the purpose of Safe and Effective Intervention and Management Approaches for Juvenile Sex Offenders and Youth with Sexually Abusive Behavior, juvenile sex offenders and youth with sexually abusive behaviors will be referred to as JSOs and youth with SAB.

II – Guiding Principles

Safe and effective intervention and management approaches for JSOs and youth with SAB represent more than standards for care and services. The program standards represent a philosophy about the way legal sanctions, monitoring strategies, and specialized treatment programs are structured, organized and delivered. The following principles guided the work of the advisory committee.

Safe and Effective Intervention and Management Approaches for JSOs and youth with SAB:

- Are victim centered, with the primary emphasis on the safety and well-being of past and potential victims, and the protection of the community; and, ensure the protection of the due process rights/civil rights of victims and their families.
- Recognize that juveniles who sexually abuse are different from adults who commit sex offenses. Responses to these youth must take into account these differences as well as their specific developmental needs.
- Recognize that juveniles who engage in sexual abuse are a heterogeneous group with diverse victim preferences, levels of risk, criminogenic needs, psychosocial deficits, health and behavioral health needs, strengths, and assets.
- Require collaboration of all community agencies, law enforcement, juvenile courts, mental health, child welfare, schools, and an integrated system that recognizes the importance of diverse perspectives, shared resources and mutual commitment to work together.
- Ensure the protection of the due process and civil rights of offenders. Firm and fair treatment that protects the community and helps to develop hope and a sense of efficacy within the offender for self management and rehabilitation.
- Provide and/ or supervise services offered by appropriately credentialed and trained staff

III – Target Population

In order to address the problems inherent in serving for JSOs and youth with SAB, it is imperative to identify the population's characteristics and understand, intervene, and treat for JSOs and youth with SAB as adolescents not as adults.

Based on a review of the research literature and programs in other states, significant inconsistencies were found in definitions and labels for this population of youth. Terminology included: juvenile sex offenders, sexually offending juveniles, sexually abusing youth, juvenile with sexual behavior problems, and juveniles with sexually abusive behavior. For the purpose of this document, the committee agreed on juvenile sex offenders (JSOs) and youth with sexually abusive behavior (SAB) as the term to describe the target population.

The target population includes:

Juvenile Sex Offender: A personal, legally or legislatively defined by the criminal code that has been charged and adjudicated of illegal sexually behavior, ORC:2907.01.

Youth with Sexually Abusive Behavior: A person legally or legislatively defined by the criminal code with a history of sexually abusing others who have not been adjudicated for a sex offense.

A crucial aspect of defining the population is identifying the characteristics of the target population. According to the *National Task Force Report on Juvenile Sex Offending*

- JSOs and youth with SAB are typically between the ages of 13 and 17;
- Are generally male;
- 30-60% exhibit learning disabilities and academic dysfunction;
- Up to 80% have a diagnosable psychiatric disorder;
- Many have difficulties with impulse control and judgment;
- 20-50% has histories of physical abuse; and,
- 40-80% have histories of sexually abuse.

As stated previously it is essential to recognize, assess, and treat JSOs and youth with SAB as adolescents, not as adults. This can be difficult to do considering the challenges to the juvenile justice system today, for instance, females are typically not identified or served (Charles and McDonald, 1997). It is a time when many are willing to give up on adolescents or punish them as adults. Many Ohioans, do not know or understand the complex issues that are the roots of sexually behavior problems in youth. We have adult-based treatment models to treat youth with sexual behavior problems. Changes in juvenile law have an impact on the

community's youth serving institutions ability to treat these youths effectively. It is critical that their sexual behavior is viewed in the context of the many formative aspects of their personal adolescent development. As children and adolescents grow and develop, their behavior patterns and self-image constantly change. Terms such as child molester, pedophile, and predator should rarely be used with this population. Identity formation is in progress during adolescence, labeling juveniles based solely on sexually offending behavior may cause potential damage to long-term pro-social development defeat the goal of reducing re-offending behavior.

Historically, services for JSOs and youth with SAB have been based on adult intervention strategies. Adult legal sanctions and adult-based treatment services are not appropriate. There are numerous factors that differ with regard to JSOs and youth with SAB and their adult counterparts. For example:

- Little support for the relationship between childhood victimization and adult sex offending; a greater proportion of juvenile sex offenders have been victimized (Righthand and Welch, 2001).
- A relatively high proportion of juveniles with sexually aggressive behavior are themselves victims of sexually abuse. This is not supported in research with the adult sexually offender (Knight and Pentky, 1993 and Righthand and Welch, 2001).
- Deviant arousal is more common among adults, a potent predictor of sexual recidivism; juveniles tend not to have fixed patterns; considerable planning often precedes adult offenses while juvenile offenses are situational and impulsive (Wienrott, 1998).
- Social deficits have been among the most common characteristics attributed to JSOs and youth with SAB, despite the fact that social competence has been found to be a poor discriminator with adult sex offenders (Minor and Crimmins, 1995).
- While many adolescents who commit sexual offenses have histories of being abused, the majority of these youth do not become adult sex offenders. (Becker, J and Murphy, W 1998).
- Available data from the Association for the Treatment of Sexually Abusers and the Juvenile Forensic Evaluation Resource Center suggest that the majority of JSOs and youth with sexual abusive behaviors are NOT predicted to become adult sex offenders. The good news is that specialized treatment programs for JSOs and youth with sexual abusive behaviors SAB

- work. Statistics are very optimistic for the juvenile offender, unlike the outcome data on their adult counterpart.
- The results of research on recidivism which typically reveal relatively low rates of sexually recidivism (8 to 14 percent) documented in over 30 national research studies (Kahn and Chambers, 1991...).
 - Research studies which assert that specialized treatment reduces recidivism by up to 40%; (Lipsey and Wilson, 1998).
 - Research does NOT support the notion of “once a sex offender always a sex offender. Labeling a juvenile without considering the developmental needs of juveniles, may contribute to self fulfilling prophecies marked by increased recidivism (Becker, 1998; and Bonner, 1997) and,
 - The positive outcomes on early, appropriate intervention with youth with sexually abusive has been evidenced in study after study (Abel, Osborn, and Twigg, 1993; and Lipsey and Wilson, 1998,).

A combination of standardized legal sanctions, monitoring strategies, and specialized clinical programming are needed to promote community safety and effective treatment of juvenile sex offenders and youth with SAB.

IV - Standards for the Assessment, Treatment, Supervision and Transition of Juvenile Sex Offenders and Youth with Sexually Abusive Behavior

SECTION 1: ASSESSMENT STANDARDS

A. Overview

A comprehensive assessment is imperative for the safety of the community, victim and juvenile. Assessments should be specific for use with the juvenile population who are suspected of inappropriate sexually behavior (adjudicated or unadjudicated). Assessments provide reliable information regarding a juvenile’s offense specific risk factors, mental health status, social skills level, cognitive thought processes, family and environmental situation and general clinical needs.

Assessments should occur at periodic intervals to measure changes in the juvenile’s individual, social, and environmental circumstances throughout the duration of their involvement with the service delivery systems. Assessment recognizes that the risk levels, needs, and circumstances of these youth change over time. The importance of ongoing assessment is critical so that the supervision strategies, clinical interventions, and other management practices can be adjusted based on changes over time.

The goals of assessment are to provide data to guide and inform key stakeholders' decisions for working effectively with JSOs and youth with SAB. These stakeholders include:

- The family and community;
- Juvenile and family court judges who use the data to sentence youthful offenders appropriately and effectively;
- Treatment providers who use the assessment data to develop treatment plans that address juveniles' level of risk and needs, to monitor treatment progress over time, and to determine the appropriate end to treatment;
- Discharge planning staff responsible for releasing juveniles from residential facilities who use the data to determine when and under what conditions juveniles can transition back into their communities; and,
- Supervision officers and caseworkers who use the data to craft and modify management and supervision strategies to hold these youth accountable for their abusive behavior and to assist them to live healthier lives.

B. Purpose of Assessments

Assessments for JSOs and youth with SAB must be comprehensive, sex offense specific and should not be used to determine the youth's guilt or innocence. Categories of assessment instruments and tools are identified in Appendix B. It is the responsibility of the assessor to make sure that any instruments used are valid, reliable and developmentally appropriate for the individual being assessed and are from the approved list found in the Appendix B.

Assessments are intended:

- To document the specific offense and/or mental health needs identified by the assessment (even if resources are not available) to address adequately the treatment needs of the sexually abusive youth;
- To provide a written clinical assessment of a sexually abusive youth's risk factors for current management strategies to increase safety and amenability to treatment;
- To guide and direct specific recommendations for the conditions of treatment and supervision of a sexually abusive youth;
- To provide information that will help professionals identify the optimal setting, intensity of intervention, and level of supervision; and,
- To provide information that will identify sexually abusive youth for whom community based treatment is not appropriate.
- The goal of assessment is to identify the context of risk of further acting out.

Assessment shall include:

- Examination of criminal justice information, including prior juvenile court history. The details of the current charges and any other alleged incidents or charges, as well as documents describing victim impact.

- Examination of collateral information, including information from other sources regarding the youth's sexually abusive behavior.
- Review of child welfare investigations and case records, where applicable.

Assessments shall be conducted only by licensed professionals who have experience working with a broad range of JSOs and youth with SAB. General risk assessments will identify the strengths, risk factors, and deficits in a multitude of areas, including but not limited to:

- Family history and dynamics
- History of living arrangements/living environments
- Social support system
- Criminal history/criminogenic factors
- Educational history/vocational history
- History of potentially abusive behavior (substance abuse/gambling/eating)
- Mental health/substance abuse history and any treatment provided
- Medical history
- Mental status assessment
- Aggression History
- Sexually behavior/history (healthy and unhealthy)
- Cognitive assessment
- Personality/mental health assessment
- Alleged offense/sexually inappropriate behavior/self-report including:
 - Context at the time of the offense
 - Behavior and dynamics leading up to the offense
 - Details of what occurred
 - Details of what happened right after the offense
 - Details of how the offense was discovered
 - Motivation for sexually inappropriate behavior
- Risk factors for re-offending or further sexually acting-out behavior
- External relapse prevention systems including informed supervision
- Amenability to treatment
- JSORN/ORC 2950.90 required information such as:
 - Offender's or delinquent child's age
 - Prior criminal or delinquency record regarding all offenses, including , but not limited to all sexually offenses
 - Age of the victim of the sexually-oriented offense
 - Whether a sexually-oriented offense involved multiple victims
 - Whether the offender used drugs or alcohol in the commission of offense to impair the victim or prevent victim from resisting
 - If the offender had previously been adjudicated a delinquent youth; if the youth child completed any sentence or dispositional order for the prior offense; if the prior offense was a sexually oriented offense, and if the child participated in available programs for sexually offenders

- Any mental illness, mental retardation and/or developmental disability
- The nature of the offender sexually conduct, sexually contact, or interaction in sexually context and if that conduct, contact or interaction was part of a demonstrated pattern of abusive behavior
- If during the commission of the sexually oriented offense the offender displayed cruelty or threats
- Additional behavioral characteristics that contribute to the offender's or delinquent child's conduct

The assessor (if different from the treatment provider) shall provide complete information obtained in the course of the pre-sentence assessment to the recommended placement and/or treatment provider with the appropriate release of information.

Assessors should indicate the limitations of the assessment process. Assessments should be conducted frequently due to the developing and changing nature of children and adolescents. Assessments should be completed every six months. Re-assessment should be completed even more frequently if the assessor becomes aware of changes (positive or negative) in a youth's life that affect risk.

C. Assessment Process

Assessments should occur at referral, throughout programming and treatment and prior to discharge.

All youth referred for services shall receive an initial comprehensive youth sexual abusive behavior assessment. The initial assessment is conducted in order to determine risk factors, level of intervention needs, treatment and supervision requirements.

Comprehensive assessment of youth with sexually abusive behavior is an ongoing process to measure the juvenile's progress in treatment, environmental change and compliance with supervision.

Prior to any change in level of care, a reassessment shall be completed. This assessment should include treatment progress made by the sexually abusive youth and his/her family, including management of risk factors. The assessment shall be the basis for professional recommendations for follow-up and aftercare services. The recommendations should consider risk factors in the environment to which the youth will return after treatment, supervision requirements, and should be consistent with the risk management plan.

D. JSORN Classification Reviews

Assessments shall conform to the current JSORN classification reviews. Ohio Revised Code (ORC) 2950.09 (B)(2) sets criteria that juvenile judges must consider

in making the determination whether a juvenile is a Sexually Predator, Habitual Offender, in reviewing recommendations by the Department of Youth Services and during appeals to reclassify or declassify adjudicated offenders.

Initial and ongoing assessments conducted at the judge's request to support the classification review process shall address all of the factors listed above for ORC 2950 requirements.

SECTION II: TREATMENT STANDARDS

A. Overview

Specialized treatment for JSOs and youth with SAB includes a continuum of services that are chosen for a particular youth based on several concerns: community safety, the victim's safety, the youth's assessed treatment needs, and, in so far as they can be identified, factors that enhance or reduces the risk for re-offense. Specific treatment for JSOs and youth with SAB, must promote accountability, increase positive coping skills in order to reduce the risk of recidivism, and is essential to rehabilitate these youth successfully. To achieve this end, interventions must employ cognitive behavioral methods and include family treatment, parenting effectiveness training and a relapse prevention component. As research on this population of youth progresses, it should guide improvements to programming and treatment, to assessment tools and the application of data gathered and reflected in treatment planning.

Specific goals and objectives of specific treatment programs for JSOs and youth with SAB will include:

- Learning to accept responsibility for their inappropriate behavior, as developmentally appropriate;
- Modifying cognitive distortions;
- Managing negative expression of feelings;
- Developing positive relationships;
- Controlling deviant sexually arousal;
- Maintaining control of unhealthy impulses;
- Feeling empathy for victims;
- Understanding precipitating factors of sexually abusive behavior and maintenance behaviors (i.e. triggers and stressors);
- Developing effective coping strategies for risk factors;
- Identifying and using support networks, including parents and families; and,
- Develop healthy expressions of sexuality.

Ohio must ensure that a continuum of service alternatives are available for JSOs and youth with SAB. In order to make the best use of scarce resources, youth must receive services that are suited to their level of need. Criteria to make this

determination should include: security of the setting, level of supervision and intensity of service.

B. Treatment Components

1. Availability, Eligibility & Access

Treatment type must be dictated by the youth's level of risk, gender, physical or developmental limitations and healthcare needs. Programs providing specific treatment for JSOs and youth with SAB must:

- Define intake eligibility criteria & the program's expectations for youth participation;
- Ensure that staff have the credentials needed to provide quality services;
- Provide offenders with information about the agency, the rules that will apply to them while they are receiving services, how to reference those rules, the agency's complaint process and, as appropriate, a discussion of informed consent;
- Define a process by which the youth is referred to services;
- Provide periodic reassessment of youth offenders;
- Collaborate when necessary, with other professionals, families and community supports;
- Have community safety plans for each youth served; and,
- Assist in transition and continuity of care from one setting to another.

2. Structure and Modality

Treatment programs for JSOs and youth with SAB shall define a clear theoretical approach that outlines the philosophy and methods of treatment.

Group treatment typically is the primary modality, however other modalities such as individual treatment, family treatment, substance abuse treatment, educational & vocational training, mental health and psychiatric services and family treatment are appropriate and necessary adjuncts, based on identified needs of individual youth.

Groups should be co-facilitated, and whenever possible, should include both a male and a female. Group size shall not exceed twelve members. Group assignment is a clinical decision which shall take into consideration age, individual risk factors, sexual behavior patterns, developmental level and groups shall be gender-specific.

3. Treatment Planning

Individualized treatment plans shall be developed by the multi-disciplinary treatment team, based on a comprehensive assessment and with participation from the youth, the family and victim when appropriate. Treatment plans shall be reviewed every 90 days or when risk re-assessment indicates the need for changes.

Treatment plans shall include:

- Specific and measurable goals;
- Specific action steps with identification of responsible parties;
- Target dates for goal attainment; and,
- Discharge/level of care criteria.

The following issues shall be addressed by the individual treatment plan:

- Focus on dynamic risk factors and/or criminogenic tendencies
- Management of deviant sexually interest and arousal
- Healthy relationships and appropriate behavior
- Challenging distorted thinking patterns
- Development of pro-social relationships and appropriate social skills
- Enhancing victim empathy
- Development of effective coping strategies
- Development of appropriate and informed support networks
- Identification of maladaptive behavior and development of adaptive behavior
- Family involvement which addresses
 - Participation in the development of the individualized treatment plan
 - Parent education and/or support groups
 - Family treatment sessions
 - Participation in relapse prevention planning

4. Documentation

Treatment providers shall maintain clear and specific documentation regarding assessment data, treatment services provided youth (and family if appropriate), youth progress and successful program completion. Treatment records must include all other relevant documents such as:

- Statement of Informed Consent
- Confidentiality Waivers
- Treatment Contract
- Individual Treatment Plan
- Relevant Medical Records
- Offense History
- Other Agency Reports
- Program Completion or Termination Summary

5. Data Collection

At a minimum, treatment providers for JSOs and youth with SAB should have the capacity to collect, analyze report and utilize the following data toward the goal of performance improvement:

- Admissions (e.g. demographics, diagnoses, developmental disabilities, etc.)
- Attendance at treatment sessions

- Attainment of individual outcomes
- Length of stay
- Discharges (e.g. to what setting, planned or unplanned, etc.)
- Post discharge follow up

6. Limits of Confidentiality

At intake, treatment providers should give the youth and their family a document which identifies the limitations on confidentiality for purposes of evaluation, treatment, supervision, and case management.

This document should:

- Specify an effective and ending date
- Outline the specific limitations on youth and family confidentiality
- Provide a clause for withdrawal of consent, without penalty
- Be based on informed consent of the parent or legal custodian and the juvenile

7. Treatment Contract

Following assessment, the youth should be provided a treatment contract written in language, easily understood by the juvenile and the parent/legal custodian, which includes the following:

- Responsibilities of the family or legal custodian and the youth
- Includes special requirements imposed by court, probation, parole, PCSA ODJFS and/or DYS
- Conditions that provide for protection of past and potential victims
- Consequences for failure to comply with treatment plan

8. Program Completion

Successful completion of the program should be based on a determination by the treatment team that the juvenile has accomplished the criteria established in their individual treatment plan which warrants a less intensive level of service.

Alternately, the treatment team may decide to terminate the juvenile from treatment because of violations of the treatment contract or because youth have not made progress on their individual treatment plans.

C. Residential Treatment Services Operational Safety Standards

The treatment needs of JSOs and youth with SAB are unique and require special standards to address safety, youth supervision and management, and the development of a therapeutic environment needed to meet the needs of the youth, community and victim(s). In addition to protocols that address therapeutic treatment, residential programs (may include public and private children's residential centers and group homes) that work with this specific population shall develop protocols to monitor and supervise youth residents and modify the physical environment to prevent inappropriate sexual contact between youth residents and others while in treatment, according to the risk levels of youths served by the program. Such protocols shall be in compliance with the most stringent standards of the bodies that regulate and credential residential treatment programs.

Comprehensive risk management requires that residential treatment programs address the following:

1. Admission Criteria

Develop and follow which identifies the characteristics of which youth the program will serve.

2. Facility Environment

Designed or modified the facility environment to safely manage the risk levels of youth residents. This can be accomplished through clear and constant actual or electronic visual monitoring (includes sleeping hours for bedrooms with more than one resident, but excludes bathroom use), windows on interior doors, sufficient bathing and toilet capacity to accommodate single use.

3. Staffing Levels and Patterns

The program maintains a staff-to-resident/youth ratio and pattern that provides adequate staff supervision. During waking hours, this ratio shall be 1 direct care staff for every 5 residents or fraction thereof. In open/non-locked settings, during sleeping hours, this ratio shall be 1 awake direct care staff for every 5 residents. Night staff should conduct regular and frequent checks, particularly in bedrooms that accommodate more than one juvenile. For activities in the community, the ratio shall be 1 direct care staff for every 3 residents. Staffing levels are maintained to assure that no resident is alone with another resident at any time.

4. Prevention of sexual contact

The program has a written policy which explicitly prohibits sexual contact between the youth and others. Program operation is designed to prevent any consensual or non-consensual sexually contact between youth and others.

5. Program response to sexual contact

The program has a written protocol for addressing sexual contact between residents and others, and follows all reporting requirements (i.e. local CSB/CDJFS, the court and the family).

6. Mixed populations

The program has a written description for each population that is served regarding how each population is housed and monitored and how their interactions with each other are monitored and/or controlled in different settings (living and sleeping, educational, and recreation areas) in order to maintain safety of residents, staff and the community.

D. Community-Based Treatment Services –Operational Safety Standards

Community-based services for JSOs and youth with SAB include home-based, group homes, foster care, day treatment and out-patient programs located within the community. Community safety is an especially critical issue; therefore safety planning and supervision are essential to deliver community-based services safely.

Safety Planning

The agency shall develop and implement a safety plan for each youth that addresses:

- Supervision of the juvenile
 - By program staff
 - By the family
 - By other (DYS, court, probation, Children’s Services, school)
- Limitations on activities, personal contact and community access
- Interagency collaboration and information sharing
- Educating key stakeholders

A decision to provide treatment for JSOs or youth with SAB in a community-based program should only be made after a comprehensive assessment of the juvenile’s risk level and individual treatment needs, which indicate that the juvenile can be effectively managed in the community, without jeopardizing community safety.

SECTION 3: SUPERVISION, TRANSITION AND RE-ENTRY STANDARDS

A. Overview

Supervision is the process of providing safety through the continual monitoring, management and evaluation of youth, family, school and treatment providers’ compliance with court order, treatment/case plans and institutional expectations. The strategies and techniques used for the community supervision of JSOs or youth with SAB are part of a broader, comprehensive approach to managing these JSOs and youth with SAB. This approach is based on a victim-centered philosophy, with the goal of reducing further victimization. It is clear that traditional supervision practices used with youth who have no sexually abusive behavior may not adequately support safety when applied to JSOS or youth with SAB to others. The primary elements required for adequate supervision of JSOs or youth with SAB are:

- Specialized knowledge and training to facilitate the management of specialized caseloads;
- Case-specific plans with prescriptive conditions of supervision to enhance victim protection, community safety, and accountability of JSOs and youth with SAB; and,
- Supervision strategies such as, surveillance, use of external supports, polygraph to promote effective monitoring and timely system responses.

B. Professionals Providing Supervision

Supervising professionals are those whose primary role is case management placement and monitoring of JSOs youth with SAB. These supervision agents may include: probation/parole officers, caseworkers, case managers, juvenile correctional officers, foster parents, and staff from out-of-home placement settings. Supervision agents must understand and demonstrate competency in the following:

- The ability to identify and address behavior that may precipitate offending behaviors;
- Identify high risk situations for each offender;
- Monitoring progress and compliance;
- Work closely with offenders and others to facilitate offenders' use of adaptive coping skills to manage risk; and,
- Intervention with external controls when warranted.

C. Specialized Knowledge, Training, and Specialized Caseloads

Training/job specialization for supervision agents or professionals promotes expertise, maximizes resources, improves consistency, and reduces unnecessary duplication of efforts in the management of JSOs or youth with sexually abusive behavior. Each agency shall designate specially trained, supervision agents to supervise these youth. Those professionals with primary case management responsibilities for youth and families shall not have caseloads in excess of 20 youth and their families.

Supervision agents within one year of appointment are required to successfully complete training in the following areas:

- Victim issues/impact
- Dynamics of JSOs and youth with SAB
 - Assessment of risk factors (i.e. polygraph)
 - Understand and identify personal and situational risk factors
- Specialized supervision techniques
 - Safety planning
 - Surveillance officers
 - Development and adjustment of specialized conditions
 - Safety teams/community support networks

- Electronic monitoring
- Relevant legal issues
 - JSORN
 - Adam Walsh Act
 - Due process
 - Competency
- Relevant treatment issues for targeted population:
 - Trauma
 - Risk factors
 - Cognitive distortions and how to address them
 - Family/community reunification planning
 - Social/physical/sexually adolescent development
 - Healthy dating skills/sexual socialization
 - Efficacy of treatment
 - Dual diagnosis behavioral health issues
- Casework
 - PSI/social history/interviewing
 - Case planning, goal writing, outcome tracking
 - Adjusting supervision levels based on risk (up or down)
 - Home visits/community supervision based on risk/need
- Burnout, secondary victimization, isolation

D. Transition and Re-entry

The continuum of care ranges from community based including home-based, foster care, group home, none secure residential, secure residential to incarceration. Transition can occur in either direction of this continuum. The primary goal of placement is victimization prevention and community safety.

A comprehensive approach to transition planning must address the needs of the JSOs and youth with SAB and increase the likelihood that these youth will return to their community as a productive and contributing citizen. Recidivism is greatly reduced by consistency within systems and full involvement of the offender and their family.

The multidisciplinary team for transition planning will:

- Review the comprehensive youth record of all offense details, police reports, victim statements, initial and ongoing assessments, documentation of treatment progress, clinical records and community safety plan
- Assign-a primary, specially trained, case manager to coordinate services, manage transition/pre-release planning and monitor compliance
- Begin pre-release planning at intake that addresses transitional needs from the institution to community placement.

- Base the transition plan on treatment compliance and seek agreement by all team members;
- Identify the need for ongoing mental health, MRDD services and appropriate community provider(s), available community supports, continuity of medication and transportation resources
- The need for substance abuse services, assessments are completed with directives and plans for the implementation of the recommendations for ongoing counseling, testing and support services;
- Educational programming established, transfer of records is complete, testing is up to date, resource assistance identified
- Vocational skill achievement and deficits identified with recommendations for continued skill development and resources identified
- Pre-employment skills and identifying employment opportunities and transportation to job is available and job coaching if needed
- Independent living skill achievement and deficits identified with a plan and supports in place to assist youth as necessary to ensure success
- Medical care accessible, Medicaid arranged or verify that health services paid by family's health care plan
- Finalization of living arrangements, including transitional services to less restrictive setting if unable to return to their family or live independently, identified provider is able to continue specific supervision counseling or aftercare support services, for youth, family and victim as recommended in discharge assessments
- Any other needs specific to the youth's needs

Whether a youth is preparing for transition from an institutional setting or community-based program providing specific programming for JSOS and youth with SAB, transition decisions are made following consultation with a case management or multidisciplinary team. These decisions are made based on community safety and progress or lack of progress towards achievement of assessment identified treatment goals. Community reintegration for youth incarcerated or placed for sexually abusive behavior should not be a privilege of only time served, but the result of a collaborative effort of service coordination. Transition decisions should be made based upon youth and/or his/her family being able to actively demonstrate the following:

- Youth's level of ownership and responsibility of all offense details
- Youth's level of participation in treatment
- Youth's understanding of level of impact of behavior on victim
- Level of accomplishment of the individualized goals identified in the treatment plan
- Youth's ability to articulate the specific goals and criteria that reflect the completion of treatment
- Youth level of ability to identify and avoid high risk situations/behaviors, available community support systems

- Parents, caregivers, and supervision agents demonstrate ability, understanding of and willingness to enact treatment goals and supervision requirements
- Youth's level of demonstrated applications of skills learned in treatment program for JSOs and youth with SAB
- Frequency of rule infractions, illegal behaviors or violations of safeguards or treatment contracts
- Youth's level of pro-social behavior, problem solving skills including the ability to accept and give constructive feedback
- Level of compliance with treatment conditions
- Level of compliance with supervision terms

If a youth is not making progress or recidivates, the provider will give consideration to the significance of the act committed, based on the youth's risk factors. Other interventions to consider are:

- Reconvene Multi-disciplinary team
- Revision/review of Transition/treatment plan
- Court intervention
- Increased/more intensive supervision
- Re-assessment of risk/needs factors

SECTION 4: SERVICE PROVIDER QUALIFICATIONS

A. Overview

Service providers experienced in working with a general population of adolescents, do not necessarily have the knowledge or skills required to provide specialized assessment, treatment, case management, or supervision of JSOs or youth with SAB.

Accordingly, standards for sex offender treatment providers must be established to ensure the quality of such services: assessment, treatment and/or supervision of this population. Specialized training and experience is required in order to work effectively with JSOs and youth with SAB, it is important that those new to the field gain the requisite training and required experience under the supervision of others, who have extensive experience in the field.

B. Level System

The following describes three levels of training and experience required for provision and supervision of sex offender treatment services. These standards are intended to augment – not replace or conflict with – the professional licensing requirements and scopes of practice as delineated by ORC 4757 (Counselors, Social Workers and Marriage and Family Therapists) and ORC 4732 (psychologists), nurses or physicians.

1. Level I Requirements

Level I includes independently licensed professionals: those who are eligible to provide clinical services including individual, group, family therapy and assessment without supervision within their scope of practice. Ohio law requires practitioners to have current, valid licenses to provide these services unless they operate within legally exempt (governmental) settings.

To qualify for Level I, the JSO/SAB treatment professional must have provided at least 2000 hours of direct clinical services (assessment, individual, family, and/or group treatment) that are specific to eliminating sexually abusive/aggressive behavior. Level I professionals may supervise staff at Levels II and III.

To be eligible for a Level I designation a service provider shall provide documentation indicating at least 50 hours of sexual aggression specific training over the past 5 years, 16 of those hours must have focused on sexual aggression risk assessment measures and techniques.

In order to maintain proficiency and to remain current on new developments in assessment, treatment and monitoring of these youth, providers at Level I must complete at least 9 hours of continuing education every year (annually). Specific focus must be on topics relating to youth with sexually abusive behavior as defined in Section C.1 of these standards. These hours may count toward professional continuing education requirements.

2. Level II Requirements

Level II professionals must have licenses from state credentialing boards or be able to document satisfactory completion of an approved sex offender specialist training curriculum, but have not met the sexually offender specific training and/or treatment experience requirements for Level I. These staff are eligible to provide services within their scopes of practice such as probation/parole monitoring, case management, and/or case planning. They may be eligible to provide sex offending specific clinical services, if appropriately licensed, but must be supervised by Level I staff. They are not eligible to supervise these specific services. They have documented 100 hours of Level I supervised sex offender specific direct clinical service.

To be eligible for Level II designation, an individual must complete 40 hours of training for working with sexually aggressive youth within the past 5 years. For the provision of non-clinical sex offender focused services (e.g. intensive supervision, group interventions, and family groups) an individual must document 20 hours of training in this area within the past 5 years.

Level II staff who intend to provide JSO specific assessments must complete 16 hours of training in the use of sex offender specific assessment tools and techniques (e.g. JSAOP –II and ERASOR) as part of the 40 hours of required training. Until Level I status is acquired, all assessments must be approved in writing and signed by a Level I supervisor.

Level II staff who provide clinical services other than assessment must complete 8 training hours annually in the areas of JSO/SAB treatment or evaluation as defined in Section III A of these standards.

Level II providers who provide non-clinical services only, must complete 6 hours of training in treatment and evaluation annually, as defined in Section III, A of these standards.

3. Level III Requirements

Level III includes persons responsible for the day-to-day care and monitoring of JSOs and youth with SAB operating as treatment and therapeutic foster parents, residential facility direct-care staff, group home direct-care staff, or who serve juveniles in a non-clinical capacity such as child protective service agency case workers, or probation or parole officers.

Level III service providers do not provide staff supervision or do not meet the training and experience requirement for Level II.

Service providers at this level must also have documentation indicating at least 20 hours of specific training focusing on youth with sexually abusive behavior. This training must be completed within 60 days of beginning work with a total of 30 hours of training received within the first year. To be eligible to provide services in a non-clinical capacity, service providers at this level must also have documentation indicating a total of 30 hours of specific training regarding JSOS or youth with SAB within the first year. Level III must complete 6 hours annually.

[Individuals with an Associates, Bachelors Degree or equivalent, in the Behavioral or Social Sciences, and are employed at least 18 hours per week in a position that provides direct clinical services to individuals who have engaged in sexually offending behavior such as probation/parole monitoring, case management, and/or case planning may qualify for Level III.]

Level	License Type	Pre-requisite training	Experience	Continuing Education
Level I	Independent	50 hours of sex-abuse specific training within the past 5 years, 16 those hours must be on sexually aggression risk assessments tools and techniques	2000 - 500 hours of direct sexually offender clinical services	9 hours every year specific to treatment strategies or assessment tools techniques for JSOs and youth with SAB
Level II	License, not necessarily independent – and/or – completion of an approved sex offender specialist training curriculum	40 hours of training within the past 5 years specific to treating or assessing JSO or youth with SAB	1000 - 250 hours of direct sexually offender clinical services	8 hours annually in the use of sex offender specific assessment tools techniques and treatment
Level III	Not necessary	20 hours within 60 days of beginning service and an additional 10 hours within the first year	None	6 hours every year after the first year in JSO and youth with SAB specific topics

C. Training Requirements

1. Training Topics

To meet the criteria for continuing education regarding working with juveniles with sexually abusive behavior, acceptable training will focus on youth and address assessment/treatment/management of youth with sexually abusive behavior and may include but is not limited to:

1. Statistics on offense, victimization and recidivism rates
2. Assessment of juveniles with sexually abusive behavior
 - a. Report writing
 - b. Interviewing and data collection
 - c. Administration, scoring and interpretation of specific assessment measures for juveniles with sexually abusive behavior
 - d. Physiological techniques including;
 - Polygraph
 - Abel screen
3. Treatment topics and techniques for juveniles with sexually abusive behavior:
 - a. Evaluating and reducing denial
 - b. Behavioral treatment techniques
 - c. Cognitive behavioral techniques
 - d. Relapse prevention
 - e. Empathy training

- f. Anger Management/Emotional regulation
 - g. Healthy sexuality development and relationships
 - h. Safety planning
 - i. Individual and group therapy dynamics
4. Offender/offense characteristics
 - a. Child and adolescent development
 - b. Dual diagnosis issues
 - c. Special needs populations
 - d. Criminogenic risk factors
 5. Victim awareness
 - a. Understand victim impact and empowerment
 - b. Family support and medication issues related to sexually offenders
 - c. How to bring victim issues in to treatment
 - d. Family reunification issues
 6. Legal and legislative issues regarding sex offenders
 7. Trauma
 - a. Victim
 - b. Perpetrator
 - c. Family
 - d. Provider/staff
 8. Specialized youth monitoring techniques
 - a. Safety planning
 - b. Surveillance officers
 - c. Development and adjustment of specialized conditions
 - d. Safety teams/community support networks
 - e. Electronic monitoring
 9. Case management
 - a. PSI/social history/interviewing
 - b. Probation case planning, goal writing, outcome tracking
 - c. Adjusting supervision levels based on risk (up or down)
 - d. Home visits/community supervision
 - e. Interagency reentry planning

2. Trainers

For a training to meet specific requirements, trainers shall only provide training within their scope of practice according to their level of competence and expertise.

SECTION 5: - SYSTEMS MAP

In order to develop and recommend safe and effective intervention and management approaches for JSOs and youth with sexually abusive behavior a common frame of reference regarding the system is required. A system map is an effective strategy for establishing a shared understanding of the system and captures how a JSO or youth with sexually abusive behavior is processed through the system, while recognizing that there is county by county variability across Ohio.

The system map identifies the steps in the case flow process beginning at the community level, pinpoints the steps that are decision points and distinguishes between steps guided by current policy or informal practices. The system map visually documents the need for collaboration in addressing the problems that cross traditional boundaries of organization and levels of government, and provides the structure for supporting the implementation of the assessment, treatment, supervision and re-entry standards. For Ohio this process has:

- Brought system policymakers and staff together to articulate what decisions they make, how they arrive at those decisions, and when (at what point) they make them in the larger process.
- Ohio's map illustrates what is known and not known about the systems, and will help establish information collection priorities.
- The process has led to probable solutions to problems and identified unnecessary duplication of efforts in the processing juvenile with sexually abusive behavior.
- Influenced the work of the community education committee members about the juvenile justice process as a *whole* and how individual team member who is responsible for one "piece" of the process impacts the others.
- Provided a framework to educate others about the juvenile justice process.

Appendix C - Systems map

SECTION 6 – COMMUNITY EDUCATION

Community education is different from professional training in many important ways. Regardless of the specific topic - whether general issues regarding safe and effective intervention and management approaches for JSOs and youth with SAB or a specific topic, community-based audiences will have different needs and expectations than professionals. Issues that need to be considered include: providing support for victims who may be in the audience; the composition of the training team; how to plan and prepare for the presentation; and the timing and location of the meetings.

The Community Education committee focused on developing curriculum and training modules and identified community organizations and targeted audience to better coordinate assault prevention programs.

The curriculum is being developed to assist community organizations plan and execute a meeting or meetings with members of the community that are designed to achieve one or more of the following goals.

To assist community members to better protect themselves and their families against sexually assault by:

- Familiarizing citizens with the resources available in their community to assist in sexually assault prevention and provide services to the victims of sexually assault
- Dispelling some of the common myths regarding JSOs and youth with SAB and their victims with facts based on research and professional experience;
- Dispelling unwarranted fears with sound information and self-protection strategies; and

Where law enforcement and community supervision agencies and others have developed a specialized and comprehensive approach to JSOs and youth with sexually abusive behavior management in the community, this curriculum may help community members to:

- Understand more clearly why some JSOs and youth with sexually abusive behavior are managed in our communities and the rationale for a specialized approach to management of juveniles;
- Understand that the successful management of JSOs and youth with sexually abusive behavior in the community means the prevention of future victimization, which is in everyone's best interests; and
- Understand and support the particular approaches and methods being employed in their own community to manage this target population.

SECTION 7 – SEX OFFENDER MANAGEMENT BOARD

The Comprehensive Approach to Juvenile Sex Offender Management Advisory Committee recommends that the Ohio General Assembly pass legislation to create an Ohio Sex Offender Management Board that has an Adult and Juvenile Division. The Board should be required to develop Standards and Guidelines for the assessment, treatment, supervision, transition and re-entry of juveniles. The Sex Offender Management Board must hold public safety as its priority, specifically the physical and psychological safety of victims, potential victims and communities.

The Standards will be required for juveniles who are placed on probation or parole, committed to the Ohio Department of Youth Services, placed in the custody of a Public Children's Services Agency, or those in out-of-placement for sexually offending or abusive behavior. Juveniles who have received deferred adjudications and those whose charges include an underlying factual basis of a sexually offense are also subject to the Standards.

The Standards will also be utilized with juveniles and families who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation. Following a comprehensive assessment, juveniles who have been adjudicated for non-sexually offenses, placed on diversion or those who are the subject of a dependency and neglect order may be included in the same programs as those developed for juveniles adjudicated for sexually offending behavior.

Sex offender treatment is a developing field. The Board will remain current on the emerging research, literature and evidence-based practices and will modify the Standards and Guidelines based on an improved understanding of the issues.

The Sex Offender Management Board will be required to establish Standards and a process for the Certification of Sex Offender Treatment Programs and staff and personnel qualifications. The Board will be required to establish an approved provider list upon which will be placed the names of all individuals and programs who are approved by the Board to provide assessment, treatment, supervision, transition and reentry services for juveniles with sexually abusive behaviors.

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APPENDICES

Appendix A - Definitions

Adjudication: The process of rendering a judicial decision as to whether the facts alleged in a petition or other pleading are true.

Adjudicatory Hearing: The court proceeding in which it is determined whether allegations of the petition are supported by legally-admissible evidence.

Assessments: The process of collecting, documenting and analyzing information in measurable terms, knowledge, skills, attitudes, and beliefs so appropriate decisions can be made regarding supervision and treatment of juvenile sex offenders. An assessment does not and cannot determine guilt or innocence, and it cannot be used to determine whether an individual fits the "profile" of an offender who will commit future offenses. Assessments are the groundwork for conducting an evaluation.

Child (juvenile): A person who is under eighteen years of age, except that the juvenile court has jurisdiction over any person who is adjudicated an unruly child prior to attaining eighteen years of age until the person attains twenty-one years of age, and, for purposes of that jurisdiction related to that adjudication, a person who is so adjudicated an unruly child shall be deemed a "child" until the person attains twenty-one years of age.

Child-Victim Oriented Offense: Any of the following offenses committed by a youth under 18 years of age when the victim is under 18 years of age and not the child of the person who commits the violation:

- A. Kidnapping (ORC 2905.01(A)(1), (2), (3) or (5))
- B. Any of the following provisions:
 - 1. Any violation of existing or former Ohio law of former law or ordinance of another nation, state, federal law, military law, or Indian tribal law that is substantially equivalent to the above offenses and that, if committed by an adult, would be a felony of the first, second, third or fourth degree.
 - 2. Any violation of existing or former law or ordinance of another nation, state, federal law, military law or Indian tribal law that is substantially equivalent to the above offenses.
 - 3. All attempts, conspiracy or complicity of any of the above offenses.
- C. If the youth is tried as an adult, any of the following offenses:
 - 1. Abduction (ORC 2905.02)
 - 2. Unlawful Restraint (ORC 2905.03)
 - 3. Criminal Child Enticement (ORC 2905.05)

Child-Victim Predator: A youth adjudicated for committing a child-victim oriented offense, who was 14 years of age or older at the time of the offenses, was classified as a juvenile offender registrant, and has been deemed likely to engage in subsequent child-victim oriented offenses. The court must order local law enforcement to provide community notification concerning the youth. Once released from DYS, this offender must register with the sheriff every 90 days until death unless a Judge removes this classification. (ORC 2950.01(U))

Clinical Polygraph: A diagnostic instrument and procedure designed to assist in the treatment and supervision of juvenile offenders by detecting deception or verifying truth of statements by persons under supervision or treatment. The polygraph can assess reports relating to behavior. The types of polygraph examinations typically administered are:

- A. *Sexual History Disclosure Test:* Refers to verification of completeness of the juvenile's disclosure of his/her entire sexually history, generally through the completion of a comprehensive sexually history questionnaire.
- B. *Instant Offense Disclosure Test:* Refers to testing the accuracy of the offender's report of his/her behavior in a particular sex offense, usually the most recent offense related to his/her being criminally charged.
- C. *Single/Specific Issue Test:* Refers to testing administered to determine truthfulness regarding one particular issue.
- D. *Maintenance/Monitoring Test:* Refers to testing verification of the offender's report of compliance with supervision rules and restrictions.

Cognitive/Behavioral Treatment: A form of psychotherapy that emphasizes the important role of thinking in how one feels and what one does.

Cognitive Distortions: A thinking error or irrational thought that juvenile offenders use to justify their behavior or to allow themselves to experience abusive emotions without attempting to change them. Cognitive distortions are ways sex offenders go about making excuses for justifying and minimizing their sexual abusive behavior. In essence, there are self-generated excuses for taking part in one's relapse patterns. These thoughts distort the person's perception of reality.

Confidentiality: The ethical principle or legal right that a physician or other health professional will hold secret all information relating to the youth, unless the youth gives consent permitting disclosure.

Delinquent Child: Includes any of the following:

- A. Any child, except a juvenile traffic offender, who violates any law of this state or the United States, or any ordinance of a political subdivision of the state, that would be an offense if committed by an adult;

- B. Any child who violates any lawful order of the court made under this chapter or under Chapter 2151. Of the Revised Code other than an order issued under section 2151.87 of the Revised Code;
- C. Any child who violates division (A) of section 2923.211 of the Revised Code;
- D. Any child who is a habitual truant and who previously has been adjudicated an unruly child for being a habitual truant;
- E. Any child who is a chronic truant.

Developmental Disability: A severe, chronic disability that is characterized by all of the following:

- A. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of 5122.01 of the Revised Code.
- B. It is manifested before age twenty-two.
- C. It is likely to continue indefinitely.
- D. It results in one of the following:
 - (a) In the case of person under three years of age, at least one developmental delay or an established risk.
 - (b) In the case of a person at least three years of age but under six years of age, at least two developmental delays or an established risk.
 - (c) In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.
- E. It causes the person to need a combination and sequence of special, interdisciplinary, or other type care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.

Drug addiction: the use of a drug of abuse, as defined in section 3719.011 [3719.01.1] of the Revised Code, by an individual to the extent that the individual becomes physically or psychologically dependent on the drug or endangers the health, safety, or welfare of the individual or others.

Dynamic Risk Factors: A set of changeable stimuli or external circumstances which are amenable to treatment, which threaten an offender's self-control and thus increase the risk of relapse

Empathy: A capacity for participating in the feelings and ideas of another.

Evaluation: Evaluation is the systematic determination of merit, worth, and significance of something or someone. Evaluation is often used to characterize and appraise subjects of interest in a wide range of human enterprises including business, criminal justice engineering, and non-profit organizations, government, health care, and other human services.

Family: A social group or collection of people who have varying degrees of responsibility for the children or adolescents who are members of the group. A family can be members united by marriage, ancestry, adoption, or relationship; members may be defined as biological, step, kinship, foster, adoptive, guardian or any person identified as providing physical care and control of the child or adolescent.

Grooming: The process of manipulation sometimes utilized by juvenile offenders, intended to reduce a victim's or potential victim's resistance to sexually abuse. Typical grooming activities include gaining the victim's trust gradually escalating boundary violations of the victim's body in order to desensitize the victim to further abuse.

Habitual Child-Victim Offender: A youth adjudicated for committing, on or after January 1, 2002, a child-victim oriented offense, who was 14 years of age or older at the time of the offense, has been classified by a juvenile court as a juvenile offender registrant and who was previously adjudicated delinquent for committing one or more child-victim oriented offenses. The court may order local law enforcement to provide community notification concerning the youth. Once released from DYS, this offender must register annually with the sheriff for 20 years to life unless a judge removes this classification. (ORC 2950.01(T))

Habitual Sex-Offender: A youth adjudicated for committing, on or after January 1, 2002, a sexually oriented offense that is not a registration-exempt sexually oriented offense, who was 14 years of age or older at the time of the offense, who a juvenile court classified as a juvenile offender registrant, and who was previously adjudicated delinquent for committing one or more sexually oriented offenses or child-victim oriented offense. The court may also order local law enforcement to provide community notification concerning the youth. Once released from DYS, this offender must register annually with the sheriff for 20 years to life unless a Judge removes this classification. (ORC 2950.02(B))

Informed Consent: The voluntary, knowing, reasoned choice of a person, or as appropriate the person's legal guardian.

Juvenile Offender Registrant: A youth who has been adjudicated delinquent for committing, on or after January 1, 2002, a sexually oriented offense that is not a registration-exempt sexually oriented offense or a child-victim oriented offense, who is 14 years of age or older at the time of the offense and has a duty to

register and comply with ORC 2905.04, 2905.05 or 2905.06 if the youth committed a sexually oriented offense per ORC 2905.05 or 2905.06 if the youth committed a child-victim oriented offense. It includes youth who, prior to July 31, 2003 was a “juvenile with sexually abusive behavior registrant” under the former definition of that former term.

Juvenile Sexually Abuser: A person, legally or legislatively defined by the criminal code with a history of sexually abusing others who have not been adjudicated for a sex offense.

Juvenile with sexually abusive behavior: A person, legally or legislatively defined by the criminal code that has been charged and adjudicated of illegal sexually behavior. ORC

Less Restrictive: The result of changing the environment in which a juvenile offender lives by decreasing security offered by the physical structure, reducing the level/intensity of supervision, allowing greater access to unsupervised leisure time activities, and permitting community of family visits. A less restrictive environment is usually the result of significant treatment progress or compliance with the treatment program and environment.

Level of Risk: The degree of dangerous a juvenile offender is believed to pose to potential victims or the community at large; the likelihood or potential for an offender to re-offend is determined by a professional who is trained or qualified to assess sex offender risk.

Mental Health Diagnosis: A mental disorder that meets criteria for diagnosis as specified in the Diagnostic Statistical Manual – IVTR or its subsequent versions.

Mental Illness: A substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, and/or ability to meet the ordinary demands of life.

Multi-Disciplinary Team: A variety of professionals (e.g., psychologists, psychiatrists, clinical social workers, educators, medical personnel, recreational staff, paraprofessionals, criminal justice personnel, volunteers, and victim advocates) working together to evaluate, monitor, and treat offenders.

Out-of-State Juvenile Offender Registrant: A youth who has been adjudicated delinquent for committing a sexually oriented offense that is not a registration-exempt sexually oriented offense or a child-victim oriented offense in another state or federal court, military court, Indian tribal court or court in any nation other than the United States and who moves to or resides in this state or is temporarily domiciled in this state for more than five (5) days and who has a duty to register and comply with ORC 2905.04, 2905.041, 2905.05 and 2905.06 if the youth

committed a sexually oriented offense or 2905.05 and 2905.06 if the youth committed a child-victim oriented offense. It includes youth who, prior to July 31, 2003, was an "out-of-state juvenile with sexually abusive behavior registrant" under the former definition of that former term.

Pornography: The presentation of sexually arousing material in literature, art, motion pictures, internet, or other means of communication or expression.

Presumptive Registration-Exempt Offender: A youth with no previous adjudication for a sexually oriented or child-victim oriented offense, whose first offense is sexual imposition, voyeurism or menacing by stalking (with a sexually motivation) and the victim of the offense is 18 years of age or older. The sentencing court may still determine that youth must register for offenses. Otherwise, these youth are not required to register.

Protective Factors: Characteristics, events or processes that decrease the impact of a risk factor and the likelihood of adverse outcomes.

Recidivism: Commission of a crime whether or not followed by arrest, charge, adjudication/conviction, sentencing or incarceration.

Relapse: A re-occurring sexually abusive behavior or sex offense.

Relapse Prevention: A multidimensional model incorporating cognitive and behavioral techniques to treat sexually abusive/aggressive behaviors in which the feelings, thoughts, behaviors, and situational contexts relating to the offending behavior are identified and specific coping mechanisms for addressing each of these feelings, thoughts, behaviors and contexts are developed and implemented.

Relapse Prevention (RP) Treatment Model: A three dimensional, multimodal approach specifically designed to help juvenile offenders maintain behavioral changes by anticipating and coping with the problem of relapse. Relapse prevention: 1) teaches youths internal self-management skills; 2) plans for an external supervisory component; and, 3) provides a framework within which a variety of behavioral, cognitive, educational, and skill training approaches are prescribed in order to teach the juvenile offender how to recognize and interrupt the chain of events leading to relapse. The focus of both assessment and treatment procedures is on the specification and modification of the steps in this chain, from broad lifestyle factors and cognitive distortions to more circumscribed skill deficits and deviant sexually arousal patterns. The focus is on the relapse process itself.

Residential Premises: The building in which a residential unit is located and the grounds upon which that building stands, extending to the perimeter of the property. "Residential premises" includes any type of structure in which a

residential unit is located, including, but not limited to, multi-unit buildings and mobile and manufactured homes.

Residential Unit: A dwelling unit for residential use and occupancy, and includes the structure or part of a structure that is used as a home, residence, or sleeping place by one person who maintains a household or two or more persons who maintain a common household. "Residential unit" does not include a halfway house or a community-based correctional facility.

School: A school operated by a board of education or any school for which the state board of education prescribes minimum standards under section 3301.07 of the Revised Code, whether or not any instruction, extracurricular activities, or training provided by the school is being conducted at the time a criminal offense is committed.

School Building: Any building in which any of the instruction, extracurricular activities, or training provided by a school is conducted, whether or not any instruction, extracurricular activities, or training provided by the school is being conducted in the school building at the time a criminal offense is committed.

School Premises: Either of the following:

- A. The parcel of real property on which any school is situated, whether or not any instruction, extracurricular activities, or training provided by the school is being conducted on the premises at the time a criminal offense is committed;
- B. Any other parcel of real property that is owned or leased by a board of education of a school or the governing body of a school for which the state board of education prescribes minimum standards under section 3301.07 of the Revised Code and on which some of the instruction, extracurricular activities, or training of the school is conducted, whether or not any instruction, extracurricular activities, or training provided by the school is being conducted on the parcel of real property at the time a criminal offense is committed.

Secure Facility: Any facility that is designed and operated to ensure that all of its entrances and exits are locked and under the exclusive control of its staff and to ensure that, because of that exclusive control, no person who is institutionalized or confined in the facility may leave the facility without permission or supervision.

Sex Abuse Cycle: The pattern of specific thoughts, feelings, and behaviors which may lead up to and immediately follow the acting out of sexually deviance. This is also referred to as "offense cycle," or "cycle of offense."

Sex Offense Specific: Assessment, treatment, counseling, or other intervention designed or developed to reduce the risk of further sexually offending and abusive behavior by the juvenile.

Sex Abuse Specific: A term used to imply aspects of treatment, assessment and programming targeting sexually abusive behaviors and not generic problems.

Sexually Predator: A youth adjudicated for committing a sexually oriented offense that is not a registration-exempt sexually oriented offense, who was 14 years of age or older at the time of the offenses, was classified a juvenile offender registrant and has been deemed likely to engage in subsequent sexually oriented offenses. The court may order local law enforcement to provide community notification concerning the youth. Once released from DYS, this offender must register with the sheriff every 90 days until death unless a Judge removes this classification. (ORC 2950.01(E))

Sexually Oriented Offense: An act committed by a person under 18 years of age that is any of the following:

- A. Fourth degree felony or higher of any of the following offenses:
 - 1. Rape (ORC 2907.02)
 - 2. Sexually Battery (ORC 2907.03)
 - 3. Gross Sexually Imposition (ORC 2907.05)
 - 4. Importuning (ORC 2907.07)
- B. Any of the following offenses if they were committed to gratify the sexually needs or desires of the offender:
 - 1. Aggravated Murder (ORC 2903.01)
 - 2. Murder (ORC 2903.02)
 - 3. Felonious Assault (ORC 2903.11)
 - 4. Kidnapping (ORC 2905.01)
 - 5. Involuntary Manslaughter (Felony level – ORC 2903.04(A))
 - 6. Abduction (ORC 2905.02)
- C. Any of the following offenses, if the victim was a minor (under 18 years of age):
 - 1. Abduction, Unlawful Restraint, Criminal Child Enticement, Corruption of a Minor (ORC 2905.01, 2907.06, 2907.08)
 - 2. Compelling Prostitution (ORC 2907.21)
 - 3. Pandering Obscenity or Sexually Oriented Matter (ORC 2907.321(A) (1) or (3); 2907.322 (A) (1) or (3))
 - 4. Illegal Use of a Minor in Nudity Oriented Material (ORC 2907.323(A) (1) or (2))
 - 5. Endangering Children (ORC 2919.22(B) (5))
 - 6. Kidnapping to engage in sexually activity or committed with sexually motivation (ORC 2905.01(A) (1), (2), (3) or (5), 2903.211))
 - 7. Sexually Imposition (ORC 2907.06)
 - 8. Voyeurism (ORC 2907.08)

9. Menacing by Stalking committed with sexually motivation (ORC 2903.211)
- D. Any of the following provision:
1. Any violation of existing or former Ohio law that is equivalent to the above offenses
 2. Any violation of existing or former law ordinance of another nation, state, federal law, military law or Indian tribal law that is substantially equivalent to the above offenses
 3. All attempts, conspiracy or complicity of any of the above offenses (including some Felony 5 offenses)

Special Populations: Any group of juveniles, who commit sexually offenses, who have needs which significantly differ from the majority of juveniles in this population. Special populations might include juveniles who, are female; are developmentally delayed; have co-occurring psychiatric disorders; or, those who have learning disabilities.

Treatment Plan: A written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives. Treatment plans identify problem areas to be addressed in treatment, proposed treatment, and treatment goals.

Treatment Progress: Gauges the juvenile offender's success in achieving the specific goals set out in the individual treatment plan. This may include: demonstrating the ability to learn and use skills specific to controlling abusive behavior; identifying and confronting distorted thinking; understanding the assault cycle; accepting responsibility for abuse; and dealing with past trauma and/or concomitant psychological issues, including substance abuse/addiction.

Appendix B – Assessment Instruments

Assessments may include a variety of tools and instruments to identify the strengths, risks, and deficits in the recommended domains. Treatment recommendations should not be based solely on the evaluation measure but as part of a comprehensive approach. A multitude of assessment instruments and tools are available. It is the responsibility of the assessor to make sure that any instruments used are valid and reliable for the individual being assessed and are from the list that follows. These assessment tools should not be modified.

Assessment instruments are categorized based on their intent and purpose.

Assessments of sex offender risk and needs

- Child and Adolescent Needs and Strengths – Sexually Development (CANS-SD)
- Juvenile with sexually abusive behavior Assessment Procedure (J-SOAP-II)
- Estimate of Risk of Adolescent Sexually Offense Recidivism – ERASOR
- Risk Assessment/Interviewing Protocol for Adolescent Sex Offenders (RAIP)

Assessments of general delinquency risk and needs

- Youth Level of Service/Case Management Inventory (Y&LS/CMI)
- SAVRY—Structured Assessment of Violence Risk in Youth—Randy Borum, Patrick Bartel and Adelle Forth. And the updated version of “The Youth Level of Service/Case Management Inventory” -- Robert D. Hoge & D.A. Andrews
- Psychopathy Checklist – Youth Version (PCL-YV)
- Psychopathy Checklist Screening Version (PCL-SV)
- Massachusetts Youth Screening Instrument, Second Version (MAYSI-2)

Assessments of sexually attitudes, interests and adjustment

- Adolescent Cognitions Scale (Hunter, Becker, Kapland & Goodwin, 1991)
- MOLEST and RAPE scales (Bumby, 1996)
- Adolescent Sexually Interest Card Sort (Becker & Kaplan, 1988)
- Multiphasic Sex Inventory – Juvenile Version (Nichols & Molinder, 2001)
- Wilson Sex Fantasy Questionnaire (Wilson, 1998)
- ABEL – Assessment for Sexually Interest / Gene Abel, M.D.
- Juvenile Sex Offender Self-Report, from Adolescent Sexually Offender Assessment Packet/ Allison Stickrod Gray, M.S., N.C.C. and Randy Wallace, B.A.

Assessments of mental health and cognitive functioning

- WAIS-III
- WRAT-III
- Kaufman IQ Test

- Weschler memory Scale
- WISC-IV
- MMPI-A
- MCMI-III
- Beck Depression Inventory
- Woodcock-Johnson Series
- Child Behavior Checklist
- BASC: Behavior Assessment Scale for Children

Assessments of Drug and alcohol use:

- SASSI
- JASAE

Assessments of Stability of functioning:

Family

- FES: Family Environment Scale
- DAS: Dyadic Adjustment Scale

Social Skills

- HIT: How I Think

Appendix C – System Map

Appendix D – Community Education

Appendix E – Sex Offender Management Board

OHIO SEX OFFENDER MANAGEMENT BOARD – JUVENILE DIVISION CREATION - DUTIES

There are numerous challenges regarding the assessment, treatment, re-entry, supervision, registration, community notification and management of juvenile sexually offenders. Specifically, in Ohio:

- (1) There is no psychometrically sound assessment tool does not exist for juveniles. There is no criterion for assessors nor a method for collection and distribution of historical information;
- (2) Ohio does not assess offenders at the point of re-entry to the community or at the termination of community supervision, for level of risk of recidivism;
- (3) Ohio does not have a coordinated statewide continuum of treatment services or multidisciplinary case management teams with authority or funding to facilitate successful re-entry
- (4) Ohio has not developed a formal collaborative case planning process to engage other state departments, criminal justice agencies and community organizations in the transition of youth from institutions to the community;
- (5) Ohio has not identified or developed an adequate number of community residential and non-residential providers to serve juvenile sex offenders during re-entry;
- (6) Ohio has not identified or developed an adequate funding mechanism to serve juvenile sex offenders during assessment, treatment, and re-entry;
- (7) Recently enacted juvenile registration and notification laws have resulted in labeling juveniles, diminished treatment options and creating barriers to successful treatment and re-entry by limiting participation in social organizations/leisure activities, and access to employment and education;
- (8) There are limited training available to professionals that prepare the adequately to serve juvenile sex offenders effectively.

The Juvenile Sex Offender Management Advisory Committee found that sex offender program staff who assess and treat sex offenders pursuant to any special sexually offender specific sentencing alternatives and who treat juvenile sex offenders assume a vital role in protecting the public. They must assess the risk of recidivism accurately in order to prevent further victimization.

The Juvenile Sex Offender Management Advisory Committee further found that the qualifications, practices, techniques and effectiveness of sex offender therapists and program staff vary widely and that the court's ability to determine the appropriateness of sentencing alternatives and recommendations for levels of supervision for juvenile sex offenders reentering their communities.

The Juvenile Sex Offender Management Advisory Committee supports high quality, sex offender therapy Public safety is best served by regulating sex offender therapists and program staff according to evidence based and/or promising practices. These regulations must apply to assessment and treatment as part post DYS supervision, parole, the Department of Job and Family Services supervision or as juveniles.

OHIO JUVENILE SEX OFFENDER MANAGEMENT BOARD

Section I – Creation of the Ohio Sex Offender Management Board – Juvenile Division

(1) Effective _____, there is hereby created, a Juvenile Division of the Ohio Sex Offender Management Board that shall consist of TWENTY members. The membership of the board shall reflect, to the extent possible, representation of urban and rural members. The membership of the board shall consist of the following persons:

Consider staggered appointments with (a) – (h) with creation of the board followed by (i) – (q)

(a) One member who can represent sex abuse victims and victims' rights organizations;

(b) One member representing the Department of Youth Services appointed by the Director of the Department;

(c) One member representing the Department of Rehabilitation & Corrections appointed by the Director of the Department;

(d) One member representing the Department of Job and Family Services appointed by the Director of the Department; and one member who is the Chief Executive Officer of a Public Children Services Agency;

(e) One member representing the Department of Public Safety, Office of Criminal Justice Services, appointed by the Director of the Department;

(f) One member appointed by the Chief Justice of the Supreme Court who is a juvenile magistrate with expertise in dealing with juvenile sex offenders

(g) One member representing the Department of Mental Health, appointed by the Director of the Department;

(h) One member representing the Department of Mental Retardation and Developmental Disabilities, appointed by the Director of such department;

(i) One member representing the Department of Education and, appointed by the Superintendent of Public Instruction;

(j) One member appointed by the Director of the Department of Mental Health who is licensed mental health professional with recognizable expertise in the treatment of sex offenders;

(k) One member who is a district attorney;

(l) One member appointed by the executive Director of the Department of Youth Services who is a member of a community corrections board;

(m) One member who is a public defender;

(n) One member appointed by the Director of the Department of Youth Services who is a representative of law enforcement;

(o) One member appointed by the Attorney General who are recognized experts in the field of sex abuse and who can represent sex abuse victims and victims' rights organizations; and

(p) One member appointed who is a clinical polygraph examiner.

(q) One member, appointed by the Director of the Department of Job and Family Services, who is a provider of out-of-home placement services and who has expertise in providing services to juvenile sex offenders.

(r) One member recommended by the Ohio Prosecuting Attorneys Association, that shall have expertise in dealing with juvenile sex offenders or family members of a juvenile sex offender;

(s) One member appointed by the Director of the Department of Youth Services in addition to the requirements specified in the above paragraphs, who shall have expertise in dealing with juvenile sex offenders.

(3) The Director of the Department of Youth Services shall appoint a presiding officer for the board from among the board members appointed pursuant to subsection (1) of this section, which presiding officer shall serve at the pleasure of such director.

(4) Any member of the board created in subsection (1) of this section who is first appointed pursuant to paragraphs (a) to (i) of subsection (1) of this section shall serve at the pleasure of the official who appointed such member, for a term which shall not exceed four years. Such members shall serve without additional compensation.

(5) Each member of the board who is appointed pursuant to paragraphs (j) – (s) of this section shall serve a term of four years. Such members shall serve without compensation.

Section II: Duties of the Board

(a) Prior to _____, the board shall adopt and prescribe a standardized procedure for the assessment and identification of juvenile sex offenders. Such procedure shall provide for an assessment and identification of the juvenile offender and recommend behavior management, monitoring, treatment services, supervision and compliance based upon the knowledge that all unlawful sexually behavior poses a risk to the community. The board shall certify programs and providers of treatment services for juvenile sex offenders that have been shown to be effective for reducing the reducing the risk of recidivism of juvenile sex offenders and that have as their first priority the physical and psychological safety of victims and potential victims and that have been shown to be effective for reducing the risk of recidivism of juvenile sex offenders.

(2) Prior to _____, the board shall adopt and enforce standards for a system of programs for the treatment of juvenile sex offenders which can be utilized by adjudicated offenders who are placed on probation, incarcerated with the Department of Youth Services, placed on parole, or placed in community corrections facilities or other licensed or certified facilities. Programs developed pursuant to this paragraph (2) shall meet all standards to enroll youth, provide programming and to prevent recidivism of additional sexually offenses. Such programs shall be structured to provide a continual supervision process as well as a continuum of treatment options for each offender as that offender proceeds through the criminal justice system. These options may include, but shall not be limited to, group counseling, individual counseling, outpatient or inpatient treatment, or treatment provided in any appropriately licensed or certified setting.

Such programs shall be developed so that, to the extent possible, the programs may be accessed by all offenders in the criminal justice system. The procedures for assessment, identification, treatment, and supervision required to be developed pursuant to paragraph (1) and paragraph (2) of this Section Two shall be implemented only to the extent moneys are available in the Sex Offense Prevention Fund created in section _____ of the Ohio Revised Code.

(3) The board shall analyze the effectiveness of the assessment, identification, and treatment procedures and programs developed for juvenile sex offenders pursuant to this article. The board shall also develop and prescribe a system for implementation of the guidelines and standards developed pursuant to paragraph (2) of this Section Two and for tracking offenders who have been assessed, identified and treated, pursuant to this article. In addition, the board shall develop a system for monitoring offender behaviors and offender's ability to maintain behavioral changes created by treatment. The results of such tracking and behavioral monitoring shall be a part of any analysis made pursuant to this paragraph (3).

(4) On or before _____, the board shall consult on and approve the risk assessment screening instrument developed by _____ to assist the sentencing juvenile or family court in determining the likelihood that an offender will commit another one or more of the offenses specified in section ORC §2907.01(D)(2), (P)(1), (S)(1)(b). In carrying out this duty, the board shall consider sex offender risk assessment research and shall consider the following as elements of risk: mental illness, psychosis, or personality disorder mental retardation and/or a developmental disability [that make the person more likely to engage in sexually violent predatory offenses]. For purposes of this subsection (5) only, "mental illness" is a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life *in a manner that predisposes that person to the commission of criminal sexually acts to a degree that makes the person a significant risk to the health and safety of other persons*. For the purposes of this subsection (5) only, "mental retardation/developmental disability" means having significantly sub average general intellectual functioning existing concurrently with deficiencies in adaptive behavior, manifested during the developmental period. If a defendant is found to be a sexually violent predator, the defendant shall be required to register pursuant to ORC §2152.191.

(5) On or before _____, the board, in collaboration with the Department of Youth Services, and the ODYS Release Authority (AND WHO ELSE?) shall develop criteria for measuring a juvenile sex offender's progress in treatment. Such criteria shall assist the court and the Release Authority in determining whether a sex offender may be safely released from incarceration pursuant to section _____ or whether the sex offender's level of supervision should be changed pursuant to section ORC §2152.85 or whether the sex offender may be discharged from probation or parole pursuant to section _____. At a minimum, the criteria shall assist the court and the Release Authority in determining whether the juvenile sex offender poses a threat to the community if released from incarceration, released to a reduced level of supervision, or discharged from probation or parole. The criteria shall not limit the decision-making authority of the court or the Release Authority.

(6) The board shall develop a plan for the allocation of moneys deposited in the Sex Offense Prevention Fund [SOPF] created pursuant to _____ among the Department of Youth Services, the Department of Public Safety, the Office of Criminal Justice Services, and the Department of Job and Family Services. In addition, the board shall coordinate the expenditure of moneys from the Sex Offense Prevention Fund with any moneys expended by any of the departments described in this paragraph (c) for the assessment, identification, and treatment of sex offenders. The plan developed pursuant to this section shall be submitted to the general assembly on or before _____ for the fiscal year _____, the general assembly shall appropriate moneys from the Sex Offense Prevention Fund in accordance with such plan.

(7) The board shall report its findings from the research and analysis conducted pursuant to subparagraph (3) of this Section Two to the general assembly, in accordance with ORC _____ no later than_____.

(8) The board shall analyze any safety issues raised by victims and communities regarding living arrangements for and the location of juvenile sex offenders within the community, including but not limited to shared or structured living arrangements. At a minimum, the board shall consider the issues raised by the location of sex offender residences, especially in proximity to public or private schools and child care facilities, and public notification of the location of sex offender residences. On or before_____, the board shall prepare and submit a report concerning the analysis conducted pursuant to this paragraph (8) and their legislative recommendations. The board shall submit the report to the _____ committees of the House of Representatives and the _____the Senate. On or before_____, the board shall adopt such standards it may deem appropriate regarding the living arrangements and location of sex offender treatment services The board shall accomplish the requirements specified in this paragraph (8) within existing appropriations.

(9) Prior to_____, the board, in collaboration with service providers, law enforcement agencies, victim advocacy organizations, the Department of Education, and the Department of Public Safety, shall develop, for use by schools, educational materials regarding general information about juvenile sex offenders, safety considerations related to living, working and going to school with sex offenders, and other relevant material. The board shall provide the statement and materials to the Department of Education, and the Department of Education shall make the statement and materials available to schools in the state.

(9) The board and the individual members thereof shall be immune from any liability, whether civil or criminal, for the good faith performance of the duties of the board as specified in this section.

(b) The sex offender management board appointed pursuant to this section shall be reviewed as provided for in ORC § (AGENCY 5 YEAR RULE REVIEW).