Virginia Department of Juvenile Justice

A Guideline & Primer for Developing Adolescent Sexual Offender Relapse Prevention Safety Plans

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Introduction

The following guidelines shall be taken into consideration when developing a relapse prevention / safety plan (RPSP) for adolescent and/or young adults with sexual offense histories within the: 1) Department of Juvenile Justice facility programs or 2) contracted continuum placements.

All RPSPs shall be developed with the broad philosophy that decision making should be premised on an adolescent's risk, needs, and responsivity, and conducted on an individualized, case-by-case basis. These plans shall minimize risk while maximizing a youth's potential for prosocial development. It shall also consider developmental factors and recognize the importance of parental or guardian supervision in guiding youth behavior. The following general guiding principles shall be considered when constructing a RPSP. Plans should:

- Give more weight to recent behavior than past behavior;
- Consider what distress may be caused to a victim(s) if he / she is exposed, in school or at home, to the individual who sexually assaulted them. Safety and well-being of the victim(s) is the priority;
- Consider what the caregiver's ability is to ensure the safety of all youth in their care. Assuming that parents are unable to monitor an adolescent who has sexually abused is insufficient. Conversely, parental capacity to supervise and support the adolescent's needs should guide the level of services designed to improve that capacity to increase successful reentry.
- Be conceptualized and begun at the front end of the treatment process, and refined, adjusted and modified as necessary during the course of treatment. It should not be put together as a last minute document just prior to reentry.
- Be constructed collaboratively with the youth for maximum "buy-in."
- Be realistic and match the reality of the youth's life. It should be plausible, possible and within reach considering the actual environment where the youth is placed.
- Be designed to identify external resources and a support system.
- Be designed with the collaboration of the youth's support system (e.g., parents, guardians, PO, relevant family members, other providers, practitioners, etc.)
- Be reviewed periodically to ensure compliance and/or need to adjust plan levels.
- Be subject to the idea that a plan is an experiment. Youth and support systems should realize that parts of a plan may be ineffective and in need of adjusting.

As the RPSP is fine-tuned the following shall be identified and updated as necessary:

- Triggers, high risk situations and relationships that lead to problematic behaviors (people, places, things, thoughts, feelings, etc.)
- Emotions that may lead to unhealthy thoughts (e.g., boredom, rejection, depression, etc.)
- Thinking errors and deviant thinking that may lead to inappropriate or dangerous behavior.

- Desired behavioral outcomes.
- Consequences of inappropriate or dangerous behaviors.
- Healthy and appropriate behavioral strategies in lieu of problematic thinking and behaviors.
- Effective coping skills, activities and relationships.

A Note on Boiler Plate Processes

RPSPs sometimes utilize common prohibitive features such as limiting contact with people under certain age ranges, limiting technology usage to avoid contact with pornography, chat rooms, email, etc., as well as limiting places an offender can go. Sometimes these parameters are set forth by the court and/or registry laws.

The following guidelines shall be used when considering prohibitive or boiler plate type parameters within a RPSP. Additionally, the safety planning process should take into consideration what static and dynamic risk factors exist and are subject to be supported (or not) by protective factors.

Supervision

Reunification

The RPSP should take into consideration the family dynamics for possible reunification. Reunification between an offender and sibling, or other family member, should only be attempted following an assessment and the subsequent approval from the victim's independent therapist (not the offender's therapist). In best case scenarios, a victim's treating therapist collaborates with the offender's therapist to jointly create a treatment plan IF reunification is a plausible and desired plan by both the victim and family. The concept of reunification cannot just be the parent's and/or offender's goal. It must be a collaborative process among all parties that is clinically paced to accommodate the victim's individualized needs. At times external factors may emerge that may stress and/or attempt to guide or lead the process of reunification, e.g., placement deadlines, financial issues, resources, etc.; however, victim trauma, victim experience and victim dynamics (age, ability to care for self, emotional stability, etc.) along with clinical decision making, should take precedence over logistics and external motivators.

Conversely, the fact that an offender has a sibling victim is not an automatic cause for a permanent separation between the two. Dynamic and protective risk factors should be equally considered along with static risk factors when designing a safety plan that considers what kind of relationship an offender and victim can have.

Therefore, language in the safety plan should consider whether or not the victim(s) is a family member, and if so, is the reunification process a plausible and desirable goal. This decision should be based on a combination of clinical decision making factors as mentioned earlier and much less so on jurisdictional policy.

The Need for Supervision When Around Younger Children

Making recommendations about whether an offender should be supervised around younger children should take into consideration:

- The individualized history of offending;
- Any patterns of offending;
- The age of victim selection;
- Who the victim(s) were and how the offender had access to them;
- Any deviant sexual arousal or preoccupation to a given population of potential victims;
- How the offender groomed and planned the offense(s), e.g., use of force, manipulation, etc.

The writer of a RPSP should conceptualize a range of suggested safety planning depending on those factors. For example, if an offender has one younger sibling victim, used manipulation and has no history of offending other children, crafting a recommendation to not allow an offender to ever be around younger children in general, or mandating close supervision around children of all age ranges is not within the actual context of the offending experience. In the end, it is not a practical recommendation and will likely overburden caregivers.

Rather, in this case example, if the victim was selected more so from opportunity, availability and passivity, a safety plan might recommend:

1) No babysitting;
2) Not being placed in positions of authority or leadership if around weaker, younger or vulnerable youth and;
3) Having appropriate responsible adult presence when around children (of a certain age range).

Creating recommendations with extreme limiting prohibitions should be reserved for youth who show established or developed patterns of age specific deviant arousal and established predatory behavior.

Developers of the RPSP should also balance risk with any court ordered rules and/or registry law, such as limitations from being in or within certain distances of schools, daycare facilities, playgrounds, fitness centers, etc., - places where children congregate. If the victim is a non-family member then reunification is not likely a sought option. However, language should account for the possibility that an offender and victim might ultimately live in the same or neighboring community, and unexpected random contact may occur. Given this, it is wiser to create language within the safety plan that addresses what the offender shall not do, what precautions should be taken and what the offender shall do if unexpected contact with the victim should occur, as opposed to language that only states the *offender will not have contact with the victim.*

From a writer's standpoint, think about whether the resident actually requires strict, rigid boundaries when around certain populations, or if those restrictions are impractical to the assessed level of risk needed for the youth to be safe and successful. Does language guide the resident to move forward and target preferred developmentally appropriate relationships or is language limiting and designed to prevent harm to others? Consider language that bridges a healthy balance between the two that is based on practical and sustainable logistics, available resources and protective factors, and how it will all come together in a real-world application. Additionally, consider what is developmentally appropriate and preferred along with options for how the resident can achieve those goals. You can always adjust later on as needed.

Technology

Limiting cell phone / smart phone use, internet, tablets and other mobile devices should be thought out and structured within reason. Today, most youthful offenders referred for sexual offender treatment have at one point or another accessed pornography. Youth who have accessed pornography span use from casual to daily dependence. Some youth have collected and traded pornography, have frequented sexual chat rooms for cyber sexual experiences and/or have accessed a variety of other social media platforms to either gain access to pornography or make contact with potential victims.

All things considered, given society's current need to use internet based technologies to apply for jobs, do school work, stay abreast of current events, maintain social relationships, communicate, etc., internet technology is a necessary and unavoidable tool. It is simply unrealistic to expect anybody to function with any sense of normality without some use of the internet. Therefore, language used for any limitations of technology should be specific to the offender and his estimated level of risk. If an offender has pornography as a high risk factor within his offense chain, limiting internet use to certain hours of the day, when appropriate adult supervision is available makes practical sense. Prohibiting all internet use is likely not a realistic choice if acclimation to mainstream societal living is the goal. The same could be said for the use of a smart phone. Graduated / increased, supervised use of a smart phone should be considered over total banishment. Then, as the youth earns more trust and takes on more responsibility, non-supervised use can eventually replace supervised use.

When designing the safety plan around technology, language should take into account what the resident's overall risk factors are. If pornography, internet chats, social media, etc., play a significant role in accessing or furthering those risk factors, consider designing safety planning limits and goals to match how much, how little, when, where, who, why and how conditions around technology should be used rather than absolute prohibition of technology. Language should also consider measurable and graduated bench marks within the plan to allow for adjustments.

Vocational recommendations

Youth who are on the sex offender registry will have specific legal restrictions that will more than likely inhibit or preclude them from entering certain career paths unless they are eventually removed from the registry, e.g., positions that oversee children, law enforcement, and fields that require rigorous levels of security clearance. In an ever changing landscape of vocations it will be difficult for clinicians and parole supervisors to identify the vast majority of jobs the registry may affect. Therefore, it is probably more helpful to the youth, his parole supervisors, and CSU constituents to identify and pursue vocational roles that don't clash with assessed high risk factors.

For youth who are not on the registry, safety plans will have more options within this domain and youth may have the opportunity to focus on careers that are potentially attainable if there are no clinical or legal contraindications. For example, a youth with one sibling victim, with a limited history of sexual offending should not be discouraged from wanting to pursue a career as a teacher. On the other hand, an individual with a serious pattern of poly-drug abuse might be prohibited from working at CVS or other anchor store that sells over the counter drugs.

Hobbies and Activities

Youth should be encouraged to add structure and developmentally appropriate activities into their daily and weekly schedule. Interests such as drawing, reading, music, sports, fitness, etc., are typical interests that adolescents are drawn to. Therefore, when considering limitations to hobbies or activities it may be more helpful to contemplate how an activity may or may not contribute to any offense specific behavior. For example, fitness centers have a variety of children's based activities (play rooms, arts and crafts, pools, etc.) and should be factored into how applicable a resource of this kind is within an individualized RPSP. Additionally, encouraging a hobby like photography may not be safe if a youth has a history of accessing child pornography. Further, restricting the access of graphic novels and monitoring the kind of art a youth engages in may be necessary for a youth with a history of using these mediums as fodder for a behavior chain with relevant triggers or high risk factors. For example, a youth with a strong desire to draw and/or paint, but has a history of accessing sexually explicit anime or graphic novels, should be monitored and guided in what art he may create rather than restricted from drawing at all.

Limits or endorsements within a safety plan regarding the participation (or avoidance) of activities should be based on developmental expectations along with risk.

Language should target what is developmentally preferred and how and when a resident can strive to achieve goals within the parameters of pursuing safe participation of an age appropriate activity.

Drugs and Alcohol

To some degree, this can be an easier area to navigate than some of the others. Ultimately, it is illegal for anyone under the age of 21 to consume alcohol or use illegal drugs in Virginia. The real point of contention comes at the level of monitoring within a safety plan. For example, a youth with little or no history of substance use might not be subject to any testing, whereas a youth with a DSM V substance abuse related disorder might be subject to random or regular drug testing, continued treatment, referral to support groups, etc.

Treatment Experience

One of the most challenging parts of the safety plan can be factoring how the treatment experience weighs on reentry recommendations. The idea that a youth may have a pattern of high risk sexual behavior, yet was motivated and cooperated with sex offender treatment will always be a delicate equation to balance. On the other hand, a youth who exhibits a low risk profile for sexually reoffending, but who was a challenge during the treatment process, tends to raise similar concerns when balancing treatment experiences with static factors. In the end, truly measuring what somebody has individually internalized from the treatment process will be a leap of faith. If past behavior is a predictor of future behavior, then recent behavior should be as comparable to older behaviors – not always a comfortable measuring stick considering all the multiple variables that may contribute to behavior (or lack thereof), especially in a controlled, residential environment.

Something worth considering was the once held belief that it was important for adolescents in treatment to disclose their sexual offense details along with their presumed sexual deviant fantasies to their group as a signal that he is accountable for his behavior, and in turn, less likely to reoffend. There is, however, no evidence that this practice has any positive impact on recidivism. The same can be true of youth who do not display an outward sense of empathy. The point of these caveats is not to minimize

the treatment experience, or discount any particular treatment practices as a potential misnomer, but rather for the writer of a safety plan to contemplate the total "big picture."

Protective Factors

In looking at how protective factors can influence a safety plan, please consider what is possible, trainable, coachable, etc., along with what resources are available to the youth entering the community. For the most part, protective factors are things that buffer and diminish the likelihood that a risk factor will influence offending. In a nut shell, the more protective factors, the greater the likelihood of positive functioning. Things that might be considered protective are positive structure, appropriate and consistent supervision, access to education, vocation, recreation, positive social streams and peers, emotional regulation, having a safe and desirable place to live, etc.

Legal

Is the resident on the registry? If so, does language account for guidance within the legal realm as much as it does to "follow" the rules? Clinical decision making should serve as a consultative device for all constituents navigating the boundaries and seams of legal restrictions and not just a rehash of policy.

Design language that helps to explore potential supports and options as much as it does any prohibitions. If the writer is able to identify what is possible, available, realistic, where resources can be found, etc., those safety plan details are equally as valuable.

General Compliance

General compliance issues within the RPSP such as maintaining appointments, keeping log books, complying with rules, etc., and their potential consequences should be thoroughly explained, understood and agreed upon by all parties within the safety plan. Additionally, evaluating compliance of the safety plan should be a system that is collaborative, realistic and measurable by the youth, his support system and professional staff involved in his treatment and supervision.

Ultimately it will be more helpful to consider language that crafts instructions, suggestions and parameters, for a variety of potential scenarios within a given risk area rather than assuming only one outcome is likely. It's an imperfect world and in the end your safety plan is not likely going to be able to account for all of the possible outcomes a resident might face as he is transitioning into the community. Therefore, language that educates, guides, troubleshoots, rewards, measures, enhances, etc., is just as valuable, if not more so than language that is written to isolate and create absolute rigid boundaries.

Polygraph and Phallometry (Plethysmography)

DJJ's position on polygraph and phallometry supports the Association for the Treatment of Sexual Abusers (ATSA) current practice guidelines as cited and referenced in this document. Therefore, DJJ shall not endorse the use of polygraph or phallometry with individuals under the age of 18, and further, shall not make recommendations of such on its risk assessment, agency reports, etc., nor refer any of its

committed, probationed, or paroled youth to clinical partners or agencies who will utilize polygraph and/or phallometry for assessment, treatment or supervision purposes outside the scope of ATSA's current guidelines.

DJJ cautions the use of polygraph and/or phallometry with its committed, probationed, or paroled individuals who are 18 years or older. Use of polygraph and/or phallometry for DJJ involved individuals, 18 years or older, shall take into consideration ATSA's practice guidelines and shall consider the individual's emotional intelligence, maturity and any intellectual disability or developmental delay. Additionally, justification for such use shall be specific to the individual, with particular regard to addressing specific aspects of the individual's offending; and how such use will improve public safety.

For Juveniles

The ATSA practice Guidelines for Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior, 2017 (pages 32-33), outlines the following on the use of polygraph and phallometry with juveniles:

"Polygraphs and plethysmography (phallometry) are physiological measurements designed for use with adults. Their use was extended to adolescents and younger children without establishing the measure's scientific validity and without full consideration of their potential for harm. In particular, no research has subjected either measurement to controlled evaluation with relevant comparison groups such as adolescents who have not offended sexually. There are, therefore, no norms against which to compare measurement results, which severely limits their interpretability. More generally, neither measurement has been shown to improve treatment outcomes, reduce recidivism, or enhance community safety. Neither measurement is regularly used outside of the United States. Indeed, some countries have banned the use of one or both measurements with minors.

Ethical concerns raised for both measurements include the potential for coercion and for engendering fear, shame, and other negative responses in adolescent clients. Further ethical concerns relate to the prospect of basing impactful decisions including those relevant to such things as legal restrictions and/or family reunification on the results of measurements that are largely unsupported empirically. Separately, plethysmography involves the ethically concerning practice of exposing adolescents to developmentally inappropriate sexual material. Without a clearly identified benefit and with a potential for harm, ATSA recommends against using polygraph or plethysmographs with anyone under the age of 18."

For Adults

The ATSA Practice Guidelines for Assessment, Treatment, and Management of Male Adult Sexual Abusers, 2014 (pages 27-28), outlines that phallometry and polygraph are not to be used as the sole criterion for the following:

- Estimating level of risk for recidivism;
- Making recommendations for release to the community from a correctional, institutional, or other non-community placement;

- Determining treatment completion; or
- Drawing conclusions regarding compliance with or violations of conditions of release or community placement.

Phallometry shall be limited to:

- Assessing the client's relative risk for sexual arousal and preferences regarding age and gender;
- Evaluating the client's arousal responses to various levels of sexually intrusive or aggressive/coercive behaviors;
- Exploring the potential role of offense-related sexual arousal in the client's sexually abusive or at-risk behavior and developing accompanying treatment goals; and
- Monitoring the effectiveness of interventions involving the modification, management, and expression of both healthy and offense-related sexual arousal.

Phallometry shall limit viewing time measures to the following purposes:

- Assessing the client's sexual interests with respect to age and gender;
- Exploring the potential role of offense-related sexual interests in the client's sexually abusive or at-risk behavior and developing accompanying treatment goals; and
- Monitoring the effectiveness of interventions involving the modification, management, and expression of both normative and offense-related sexual interests.

Polygraph shall be limited to the following purposes:

- Facilitating a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors (generally disclosed in the interview portion of the examination);
- Eliciting from the client clarifying information regarding the instant offense/index offense;
- Exploring potential changes, progress, and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or
- Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination and interview.

In conclusion, any consideration to include the use of polygraph or phallometry as part of a court ordered probation strategy, risk assessment or treatment compliance tool, and/or parole safety plan, should adhere to the above cited principles. Any use of polygraph or phallometry beyond these principles is not endorsed by DJJ and are outside the instructional scope of this RPSP guideline.

Putting It All Together

Writing a well thought out RPSP is more of an art form than it is an exact science. It is an experiment in goal setting. The safety plan at its most basic construct is simply a composite set of instructions for the youth with a very specific set of players who help enforce and guide the youth to meet the goals set

forth in the plan. Whether or not a PO, therapist, clinician, mentor, or the youth and his family are able to follow the plan will hinge on everyone's logistical reality- that, and the ability of the *system* to monitor and enforce the safety plan. Therefore, it is imperative that the initial safety plan be written with consideration to promote conditions that mitigate the most success. In the end, if you build a safety plan that is so demanding that even the most well intentioned youth cannot follow, what is the point of it all?

Safety plans can be written with short demonstrative bullets that indicate absolute things to do or not to do, or they can be descriptive and informative. Or they can be both. Well written safety plans take into account as many of the youth's overall risk dynamics, family dynamics, offense history, treatment experience, strengths, supports, accomplishments, protective factors, etc., and instruct the youth and its constituents on *what, how and when* to do something, in addition to *not doing something*. Additionally, well thought out safety plans are crafted with a sense of balance that consider overall safety with creative mechanisms, options, instructions, etc., to maximize success. They take into account what the support system can do for the youth, what is possible, what is preferred and what will yield the greatest possible outcome.

In contrast, creating a safety plan that utilizes extreme, heavy handed, ultra conservative logistical approaches should be rare and reserved only for the highest of the highest risk based youth with little to no protective factors, extremely poor impulse control, clearly defined patterns of deviant sexual arousal with a history of acting out behaviors in multiple forums, environments, etc., and with little to no coping skills.

The Safety Plan Writing Team process

In order to create a functional and collaborative safety plan for the resident and all involved, it is important that all constituents in the resident's safety plan be able to recognize their individualized roles, and equally as important, have a structured organized method to communicate their opinions, ideas and concerns to the developer of the safety plan. Additionally, clear parameters for reviewing the safety plan at various intervals should be set and scheduled to measure a resident's progress, challenges, etc., with opportunities to adjust and/or continue the safety plan as necessary.

The Parole Officer should be the primary logistical driver behind the safety plan. Typically, it is the PO that acts as the liaison amongst the law, courts, the resident and his family. The PO also acts as the authority to approve community placements, makes referrals to community treatment providers, community resources, etc., in preparation for reentry. It therefore makes sense for the PO to act as the final authority in the management of the safety plan.

The resident's Sex Offender Treatment Provider should be the primary architect behind creating the language that best illustrates how identified risk factors are to be addressed in conjunction with reentry resources and protective factors. If the PO is the final authority in the management of the plan, the clinical team (primary clinician, clinical assessors, clinical supervisor), is the final authority in directing the how's, when's, where's and why's of navigating behavioral dynamics.

The resident must be involved in the safety planning and is the most important individual in the entire process. If the resident has involvement in the goal setting of the safety plan from the onset of the design, and is able to give feedback and voice his feelings with regard to the intensity and logistical

ramifications of how goals within the plan are created, any *buy-in* to the plan will help maximize compliance.

The family and/or other individuals within the community who are deemed to be the resident's support system and a protective factor should be brought into the safety planning dynamic as appropriate. Knowing who the players are, and what skills, attributes, etc., each one brings to the plan is important when noting possible options and limitations within the plan – especially when crafting direction around supervision, monitoring activities, behaviors, etc. Equally as important is for the team to understand how and when a support, supervisor, etc., is available when imagining how they (the support system) might monitor and sustain safety within the plan.

Treatment providers and/or other professionals who are referred to provide reentry services should be consulted and invited to collaborate, where appropriate. A key point in the transition between residential treatment and a follow-up community level clinical service, especially involving sexual offender treatment, is to match next-level clinical service intensity with the appropriate resource.

Case Examples

Consider the following basic case examples with some safety plan options.

Oliver

Oliver is 16 years old. He is being released from a residential sex offender treatment program in one month following 10 months of working on issues related to the sexual assault of his then eight year old brother and 10 year old sister. His offense history consisted of fondling and digital penetration of the sister's vagina approximately 5 times over two years. He manipulated and coerced his brother to suck his penis approximately 20 times over the course of two years. Oliver admitted to extensive access of pornography on his parent's laptop and assigned school tablet. He admitted accessing pornography and masturbating to heterosexual adult images when his mother was at work approximately 4-6 times weekly. Oliver was caught when the sister finally disclosed her abuse to a teacher. Oliver had no victims outside the family. No drug or alcohol use noted. Father is divorced and lives in California. Mother works full time as a nurse, but is involved in family therapy. Both siblings have been participating in their own therapy (for victimization) and are willing to participate in reunification. Facility reports, therapy notes and a current risk assessment highlight good participation in treatment with genuine efforts. He has one more year of high school before graduation. He is not on the registry. He is funded for 4-6 months of outpatient therapy and 6 months of probation following discharge.

While there are several points from Oliver's case example that could be discussed in a safety plan, let's use two for discussion on phrasing and options.

Pornography
Is the issue pornography, technology or both? Consider the different ways a safety plan could be worded around this topic.

Example 1 (More Dynamic)

- Oliver should be supervised / monitored by an appropriate adult (as decided upon by his support system) when using a computer, tablet, etc., for the following purposes:
    - Internet use for educational purposes, homework, school projects, etc.
    - Email
    - Social media such as Facebook, Instagram, etc., should be restricted until Oliver shows three months of responsible general internet use.
    - Casual browsing on the internet should be limited to 30 minutes a day and only when under the supervision of his mother.
- Accessing pornography or sexually suggestive anime is prohibited and any known access should be reported to his therapist and PO.
- Cell phone / smart phone use shall be limited to only phone calls with limitations on when and where Oliver may have a phone in his possession. The onset of this privilege shall be decided and/or modified at the discretion of Oliver's support team including his parole officer, therapist and mother.

Example 2 (Not dynamic at all)

- Oliver should not be allowed any access to the internet until he is off parole. This includes possessing or using any computer or mobile device, cell phone, etc., for any reason. Access to pornography or sexually explicit images is strictly prohibited.

Example 3 (Vague)

- Oliver should only have access to a computer if he is assigned homework. His use should be monitored by an adult at all times.

The guidance on pornography for Oliver is not perfect in any of these examples. But it's important to remember that safety plans are more helpful when options and flexibility are added to address the endless amount of potential scenarios that might be encountered when considering that technology use is hard to avoid in a technology based world.

The first example gives the youth and the support team a range of choices with some room to operate in the real world. Please remember that your instructions will be taken seriously and you will be asking a group of people to follow your suggested rules. What you write is only doable if it is realistic and timely. If parole is set at six months, is it more prudent to create a safety goal around pornography and technology that is built around adding responsibility during a six month time frame, or is it safer if any and all tech products are prohibited until after parole? Which position you take on the spectrum of suggestion is an experiment that you are basing off the risk assessment and all the other dynamics and variables that were pointed out earlier in this section.

Contact with Victims

This point is probably one of the most frequently addressed areas in a safety plan. Consider the various directions in these examples.

Example 1. (More Dynamic)

- The following conditions shall be met for Oliver to have contact with his siblings. The treating therapist for both siblings (in tandem with Oliver's therapist) shall be the primary professional to advocate / endorse reunification therapy with Oliver and his siblings at the convenience and clinical preparedness / readiness of the siblings (to be determined at such an appropriate time) as approved by the courts (if applicable).
- At time of discharge Oliver's placement options shall take into consideration the clinical preparedness of his siblings, reunification process, and their state of safety, trauma and emotional wellness.
    - If placement in the home is preferred by all involved, Oliver shall be supervised at all times when around his siblings.
        - Practical privacy / boundary rules and norms shall be concretely determined and monitored by the family and endorsed by the support team.
        - Any decrease of the supervision / monitoring process between Oliver and his siblings should be discussed amongst all therapeutic professionals and

caregivers involved in the reunification / contact process with collaboration of the court (if applicable).
    - If placement is in a group home, or with a relative, or another community based home, Oliver's contact with younger, passive or emotionally vulnerable youth shall be supervised and monitored for sexually aggressive behavior.
    - Any contact with siblings should follow supervision guidelines as cited above.
- Regardless of placement, Oliver should be encouraged to interact with age appropriate peers and respect age appropriate boundaries. The following general rules shall apply to any placement:
    - Oliver shall leave the door to any room open when he has a guest or visitor, or if he is the visiting guest.
    - Oliver shall obey designated curfew rules set forth by his mother, guardian and support team.
- Violations of the above rules shall be reported to the support team.

Example 2. (Not Dynamic)

- Oliver shall not have contact with his victims.
- Oliver shall not have contact with any child or peer unless he is supervised by an approved adult.

These two safety plan ideas are very different.

The first example leaves flexibility to account for the various dynamics that may or may not occur with the reunification process and takes into consideration *where* the siblings are in the therapy process. It also addresses some very basic supervision rules for being around his siblings and other children, yet doesn't provide too much restriction that could flood the family with rules and extreme boundaries that may end up creating unnecessary stress.

The second example discounts what, if any, events are occurring that might either mitigate or aggravate the therapeutic experience among the offender and his siblings. It's just a guideline with no weight given to what the family needs or wants, nor does it account for any successes or goals to strive for. It also assumes that Oliver is a potential danger to any youth or peer regardless of what we know about him. If what we know about Oliver leads us to believe that he targeted his two siblings out of convenience and opportunity, but he endorses age appropriate sexual fantasies, then assigning a guideline to supervise him when around any child and peer is simply covering all the bases, and is perhaps too broad a sweep with some very unrealistic and logistically difficult tasks to follow. This would preclude Oliver from having any alone time with a peer, potential date, etc. Imagine trying to enforce this rule in the hallways of a high school where he may be enrolled. It would also mean that Oliver and a friend couldn't sit in a movie theater without being monitored. Chaperones are important. But the level and frequency of supervision should be developmentally appropriate and primarily target behaviors that are relevant and most recent.

Harry

Harry is 18 years old. He was committed on the sexual assault of a 16 year-old girl when Harry was 17. His sexual offense history is limited to this onetime event, but there are some accusations of Harry being verbally sexually inappropriate with other girls that are similar in age to him. The sexual offense consisted of attempted intercourse at a party. Harry claimed he knew the girl and had dated her, however, it is unclear if the two have had sexual contact in the past. Harry had occasional contact with pornography and denies any history or pattern of rape fantasies. Harry additionally has an extensive history of court involvement stemming from robbery, breaking and entering and assault. Harry was committed to DJJ and sent to a residential program to complete sex offender treatment. Harry was not compliant with the program at the beginning and was frequently known to circumvent rules. He was involved in two fights, both with the same youth who Harry claimed disrespected him. After five months Harry made better strides. He is due to be discharged to his home in one month. His family is his grandmother and an older sister who is 21. He is not on the registry.

Here are some potential safety plan points of discussion.

Victim contact / Supervision Issues

Example 1 (More Dynamic)

- Harry shall have no physical, written or social media based contact with his victim.
- Harry should be placed in a community setting that is separate from the victim of his offense to ensure that no random contact occurs, e.g., at school, in the neighborhood, etc.
- If Harry is placed in an independent living program, group home, etc., he shall comply with the rules of the placement
- Harry shall be monitored by a responsible adult (as appropriately designated by his PO) when around same-aged peers.
- Harry should not be placed in positions of authority over peers without appropriate staff guidance, e.g., school groups, projects that involve group interaction and/or collaboration, etc.
- Harry should not be placed in positions to baby sit or oversee the wellness of children.

Example 2 (Conservative Sweep)

- Harry shall have no physical, written or social media based contact with his victim.
- Harry shall have no unsupervised contact with children that are two or more years younger than he is.
- Harry shall not take a job or be present in places where youth congregate, e.g., community pools, arcades, church youth centers, mall loitering, attend parties, etc.

In these examples we see Harry having different issues than Oliver.

The first example is tuned to the idea there will be no reunification. There's no point addressing it since it is rare, if ever, that reunification is sought for an offender and victim who are anything outside of the same nuclear family – or a close extended family member. And therefore, the first bullet is relevant and concrete. The remaining bullets are free to focus on the circumstances of supervision with youth and

peers. Stylistically, when around same aged peers, the word *monitor* was chosen to give a living placement more options. The word monitor could allow for supervisors to be in the general vicinity if the logistical make up of a group home placement could not secure an *eyes-on* all residents at all times. Additionally, the phrasing of *not being placed in positions of authority without staff guidance* is explored and favored more than the idea of a rule that would *eliminate* contact with children. This opens the door to modeling preferred and developmentally appropriate peer interaction. The assumption in this plan is that Harry's offense history is part of a larger behavioral scheme of violating rules in general, more than the motivation to commit further sexual offenses against peers or offend against children.

In the second example, the idea of authorizing *no unsupervised contact with children two or more years younger* is seemingly irrelevant since the victim was actually only one year younger than Harry at the time of the offense. Additionally, there is no identified pattern of deviant sexual arousal that would reinforce the belief that this particular age range is a risk factor. Add in the limitations of being in any place that youth might frequent, and Harry's options to exist outside of his home placement might be fairly limiting. The third bullet precludes Harry from working or congregating around children in public social arenas. It seems this rule might be too conservative and would mostly likely preclude Harry from being able to navigate around some very general areas that might not be relevant to his risk.

Relapse Prevention Safety Plan Worksheet (Youth Version)

Name _____ Date _____

List potential high risk situations or triggers (events, thoughts, feelings, behaviors, people, places, things) and what plan and/or coping skills you might use to address them.

High Risk Situations / Triggers	Plan / Coping Skills to Address the Situation

List people in your support system and how you can contact them.

Support People	How to Contact Them

List of short and long term personal goals.

Short Term (within six months)	Long term (longer than six months)

List of positive activities / hobbies you are interested in.

Use this space to add any continued information from a previous section:

Relapse Prevention Safety Plan Worksheet (Staff Version)

The following worksheet is a tool to help guide the creative thinking process in safety planning. The content listed below is only a sample of potential planning areas and is not meant to encompass all the possibilities a safety plan might and should address. As with any safety plan, it should be individualized and specifically tailored to the unique static and dynamic risk factors of each resident.

Consider the range of safety precautions from a spectrum of choice.

Most Restrictive / High Logistics — Least Restrictive / Less Logistics

Limits and boundaries are absolute and rigid with little to no room for individuation. Goals are not relevant. Do this… OR, Don't' do that…

Limits, boundaries and situations are conditional. If this, then let's do that… When it's here, we do this… OR, if it's not there, let's allow for this…

Limits are issued by variables that are measured to account for successes and challenges based on individualized goals and potential protective factors rather than permanent absolute conditions. When successful at this stage, we allow more of this… OR less of that…

When developing a Relapse Prevention Safety Plan, the following domains should be addressed as initial starting points (where applicable) to maximize the individualized approach. Changes and updates can occur at scheduled intervals or as necessary.

Supervision	• Is contact with former victims authorized? If so, how, when, where, and under what conditions? If applicable, comment on the reunification process. • Is supervision warranted around non-victims? If so, who are they? Is there an age range or vulnerable population of people to note? If so, describe the conditions of supervision and/or monitoring and who is responsible to ensure these parameters are met. • Are there specific conditions and limits of privacy? If so, describe them. • When and how are these supervision parameters to be measured for compliance?
Technology (computer / phone, mobile devices)	• Are there any high risk factors, concerns, challenges or limitations connected to the use of technology? If so, comment on the dynamics and how tech devices are relevant and should be limited, supervised, monitored, etc., and under what conditions (when, where, how and who). • When and how are tech goals to be measured for compliance?
Vocational	• Are there any legal restrictions to employment, training or the pursuit of a vocational interest? If so, discuss. • Are there any behavior chains, high risk factors, substance abuse or other clinical issues, etc., that might impede the pursuit of a vocation? If so, discuss. • How can these issues, if any, be safely addressed to maximize success?
Hobbies and Activities	• Are there any legal issues, behavior chains, high risk factors or other clinical issues, etc., that might limit or be challenging to the pursuit of a particular hobby, interest or activity? If so, discuss. • If applicable, how can a hobby, interest or activity be pursued safely? Describe the conditions.
Drugs and Alcohol	• Does the resident have a history of substance use or abuse? If applicable, describe what treatment options, supports and relevant intensity is needed for reentry and how these goals can be measured. • Be careful to honor confidentiality and laws surrounding substance abuse privacy (42CFR guidelines).
Treatment	• Is the resident continuing any form of clinical treatment? If so, comment on what it is and what the expectations are for successful participation. • Is treatment completion a goal, or is ongoing participation the goal? • Are there specific areas of treatment that need special attention or focus? Which ones and why?
Protective Factors	• Who is the resident's identified support system? • Are there specific people assigned for specific areas, tasks, etc.? • Identify supports and under which conditions they act as protective factors. • Identify other areas that mitigate client protective factors.
Legal	• Is the resident on the registry? If so, what are the restrictions and rules? • Are there any court ordered restrictions? If so, are there any special

	circumstances or conditions to be met? • Discuss how the resident can best navigate any legal restrictions to help maximize success in the community.
General Compliance	• How and when will the safety plan be measured for compliance? • Are there specific rewards and/or consequences for achieving or failing to meet goals? What are they? • Are there specific drivers or persons responsible for assessing success or challenges? Identify the drivers as applicable.

Resources

ATSA Practice Guidelines for Assessment, Treatment and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior 2017.

ATSA Practice Guidelines for the Assessment, Treatment and Management of Male Adult Sexual Abusers 2014.

Handbook of Assessment and Treatment of Adolescents Who Have Sexually Offended, The Safer Society, 2017.

Understanding, Assessing, and Rehabilitating Juvenile Sexual Offenders, Second Edition, Phil Rich, 2011.