

Service Standard for Residential and Group Home Services for Treatment of youth with Sexually Harmful Behaviors

This service standard is an addendum to the Residential Treatment Services Provider Contract for those programs who provide treatment services for youth with sexually harmful behaviors.

1. Service Description

- a. Services must be restricted to youth with sexually harmful/reactive behaviors. Services may be provided to families and children involved with the Department of Child Services, Probation, Department of Corrections, Department of Education and/or Private Pay. Ages and genders of the youth served must fall within the scope of the provider's license and program description for this population.
- b. Specific treatment is necessary for youth who engage in sexually abusive/harmful behavior.
- c. This standard is designed to improve the public safety by reducing the risk of reoccurring sexually abusive behavior.
- d. In addition to meeting the basic needs of the child for safety, shelter and normalcy, this program will provide intensive evidence-based services to address any mental health needs of this population, including PTSD, substance-related disorders, depression, anxiety disorders and a wide range of symptoms associated with complex trauma.
- e. The residential provider will coordinate services provided by an interdisciplinary team, and the anticipated length of stay will be determined by the agency's current program description and youth's progress in treatment based on treatment planning of individual needs.
- f. This service standard relies on best practices trainings and licensures of individual clinicians/agencies. DCS does require adherence to best practices as established by the industry (i.e. IN-AJSOP/ ATSA):
 - i. IN-AJSOP teaching/trainings
 - ii. Standards from the Association of Treatment of Sexual Abusers (hereby referred to as ATSA) that reflect current research and best practices. The standards of the association are described in Practice Guidelines, Assessment, Intervention and Management with Adolescents Who Have Engaged in Sexually Abusive Behavior.
 - iii. Up to date Practice Guidelines can be obtained via ATSA (<http://www.atsa.com/>) or IN-AJSOP (Indiana Association of Juvenile Sex Offender Practitioners). www.in-ajsop.org
- g. It is the responsibility for those fulfilling the services listed below to have made themselves aware and knowledgeable on the current ATSA Adolescent Practice Guidelines, Assessment, Intervention and Management of Adolescents Who Have Engaged in Sexually Abusive Behavior.

2. Program development

- a. Services must include ongoing risk assessment and monitoring of progress (see assessment section below)
- b. An agency will have a written program description that includes the following elements:
 - i. The mission and vision of the program;
 - ii. The target population and how youth and families enter the program;
 - iii. How the assessment is to be conducted in the initial portion of treatment
 - iv. How the assessment's conclusions/results/recommendations are connected to the youth's individualized treatment programs and their family;
 - v. The specialized training requirements for all level of employees providing care and supervision in the program;
 - vi. The core components of the program include the following:
 1. Evidence based programs within the larger residential population;
 2. Best practices/emerging practices for youth with sexual behavior problems in your program;

3. A program structure that integrates and organizes the program components (often a phase system);
 - vii. Program interventions (frequency and modality) and how the program is organized to ensure each youth receives the appropriate level of services based on risk level.
 - viii. Identification of the criteria for progress in the program and program completion;
 - ix. The discharge planning process and expectations;
 - x. The recidivism outcomes of program completion.
- c. Agency will utilize their written program description to identify core clinical components of their program. Core clinical components should be built on the Risk-Need-Responsivity model.
- i. Clinical interventions are directed by the following principles:
 1. Risk and Needs dictate type and target of interventions-
 - Risk assessment is an integral and ongoing part of the treatment program (formal and comprehensive assessments identify treatment needs and goals)
 - Risk assessment is necessary before any change in level of care or intervention (e.g. change in the safety plan, transition to less restrictive setting, readiness for clarification, etc.).
 - Treatment is based on the risks identified in a formal risk assessment process.
 - Dynamic risk factors are the primary targets of intervention.
 - Each dynamic target is measured regularly to provide evidence of reduced risk.
 2. Identified Family Engagement is a central focus of interventions and programming-
 - Family involvement in the development of a treatment plan and the measurements of outcomes is a key component to the program and is ongoing throughout the process of treatment.
 - Family engagement is identified as a measured risk reducing variable.
 - If an identified family is not available, specific actions to identify and engage an appropriate support system occurs.
 3. Responsivity
 - Obstacles to treatment progress are continually assessed and addressed in treatment.
 - Interventions identify and build on existing youth and family strengths.
 - Prosocial skill building is a primary component of the program.
 - Developmentally appropriate healthy sexual behaviors are taught, practiced and reinforced as a primary component of the program.
 4. Agency must have a progressive improvement process (e.g. five-year plan) in place that demonstrates the clinical components are implemented consistently.

3. Program Components

a. Assessment

- i. Prior to residential or group home placement a sexual risk assessment by a professional who is specifically trained (see qualifications section), must be completed to identify risk, needs, and responsivity with the youth.
 1. It is the expectation that an assessment is done prior to residential or group home consideration via Outpatient or community services and/or as part of a Diagnostic and Evaluation Residential Program.
 2. Prior to admission the agency should acquire documentation to ensure appropriateness of placement. Appropriate types of documentation may include:
 - a. Completed 311 report
 - b. Summary of allegations and other relevant historical information
 - c. Victim Statement
 - d. Police reports

- e. Previous treatment summary/documentation, if applicable.
- 3. In the event the assessment was not completed prior to admission, a credentialed provider must complete the risk assessment within 14 days of admission.
- 4. If no assessment was completed prior to admission the provider will contact either the Clinical Services Specialist or Probation Services Consultant to ensure their knowledge of the placement.
- ii. Assessments are an ongoing process as part of treatment. With the population of youth with sexual behavior problems, risk-needs-responsivity shall be re-assessed every 6 months, and/or sooner if new case information comes to light that could change risk-needs-responsivity. All updated risk assessments must be sent to the placing agency upon completion.
- iii. As part of the re-assessment, which shall occur at six months after intake, the following should be addressed, especially if new or information has changed.
 - 1. Youth, family, and community strengths
 - 2. Cognitive functioning results, as needed
 - 3. Social/developmental history
 - 4. Current individual functioning
 - 5. Current and historic family functioning
 - 6. Delinquency and conduct/behavioral issues
 - 7. Substance use and abuse
 - 8. Sexual Assessment (including sexual interests)
 - 9. Mental health assessment
 - 10. Sexual history
 - 11. Trauma history
 - 12. Community risk and protective factors
 - 13. Awareness of victim impact
 - 14. Quality and availability of informed supervision
 - 15. Risk/Need estimate utilizing an appropriate tool(s) listed below in addition to structured clinical judgement:
 - a. PROFESOR- Protective + Risk Observations for Eliminating Sexual Offense Recidivism
 - b. MEGA- Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing
 - c. MIDSA-Multidimensional Inventory of Development, Sex, and Aggression
 - d. JSORRAT- Juvenile Sexual Offense Recidivism Risk Assessment Tool- II
 - e. J-SOAP- Juvenile Sex Offender Assessment Protocol- II
 - f. J-RAT- The Juvenile Risk Assessment Tool
 - g. Visit in-ajsop.org for more details and up to date information tools.
 - h. Clinicians who administer and interpret results must meet the qualification of the testing tools being utilized.
 - 16. Conclusion of the Assessment/Reassessment shall include:
 - a. Statement of risk for continued sexually abusive behavior by environments (at least home, school, and community)
 - b. Recommendation concerning the level of restrictiveness for the youth
 - c. Statement of amenability to interventions of the youth and family
 - d. Statement of protective factors
 - e. Statement of needs for youth and family
 - f. Recommendations for intervention to address the needs of youth and family

- g. Recommendations of critical individuals in the family and community to support interventions
- h. Statement of specific responsivity factors
- i. Recommendations for strategies to address responsivity factors
- b. Progress/Monthly Reporting
 - i. Monthly progress reports must include any issues or updates with safety plans as well as risk/needs/responsivity

4. Therapeutic Services

- a. Polygraphs are not endorsed by DCS, as it is not best practice in working with juveniles.
 - i. DCS is aligned with ATSA guidelines that state there is no research to address utilizing polygraphs with juveniles; therefore, polygraphs should not be utilized with juveniles.
 - ii. An individual court order must be obtained for each polygraph. In addition, the court order must be submitted with the invoice for reimbursement.
- b. Therapeutic Services must be provided by a CSAYC, or equivalent, therapist on staff.
- c. Family to be identified by the client and team; Family contact to be completed on a weekly basis and therapy sessions at a minimum two times per month as clinically appropriate.
 - i. Identified family members will work with therapist to create dynamic safety plan and update as needed.
 - ii. Parent components including:
 1. Encouraging support for treatment and behavior change
 2. Encouraging supervision and monitoring
 3. Teaching recognition of risk signs
 4. Promoting guidance and support to their child
- d. Individual therapy is to be at least weekly with focus on sexually harmful behaviors and other identified issues in the treatment plan.
 - i. Individual must work with therapist to create dynamic safety plan and update as needed
- e. Group components for youth with sexual behavior problems could include the following:
 - i. Core treatment modules through an optional group component including psychoeducation about the consequences of abusive behavior.
 1. Increasing victim empathy
 2. Identifying general risk factors
 3. Promoting healthy sexual attitudes and beliefs
 4. Social skills training
 5. Sex education
 6. Problem solving skills
 - ii. Dynamic safety planning
 - iii. Family support services
- f. If reunification is the permanency plan, the CSAYC or practicum CSAYC (or equivalent as approved by DCS) working on the case will ensure the victim clarification process is handled within best practices. Victim clarification must be completed prior to reunification. Best practices will ensure safety throughout the clarification process, as well as how safety will be addressed during and after reunification.
 - i. When the victim(s) is in the reunification plan, the residential provider is responsible for initiating and coordinating clarification with available victim(s) from day of admission. This to include consent of information and obtaining releases of information to communicate with victim's therapist. If unable to contact the victim(s) therapist or family unwilling to sign for release of information, the court must be notified immediately.
 - ii. Reunification and clarification steps/goals should be discussed in all team meetings. Clarification does not equate to reunification.
- g. If a provider is in active status of CSAYC field instruction and under clinical supervision of an individual who possess CSAYC, a service provider is eligible to provide services.

5. Discharge Planning

- a. Discharge planning for reunification and alternative placements will begin upon admission
- b. To determine if discharge is appropriate, the provider shall complete a re-assessment of risk.
- c. Prior to discharge when youth is reunifying with victims, clarification and safety planning are completed. All team members are aware of transition process for successful reunification. A transition of reunification has been in practice and safety plans were updated upon transition issues.
- d. All youth discharging to the community shall have experienced home/community passes as an option of utilizing their safety plan and pro social skills.
- e. Safety plans for discharge shall begin upon admission as most restrictive and as treatment progresses and behavioral improvements noted, safety plans can be adapted.
- f. While there is no perfect answer on when a youth shall be discharged, the following shall be taken into consideration:
 - i. Dynamic risk factors have decreased and addressed in safety planning
 - ii. Protective factors are identified
 - iii. Static risk factors are addressed as needed in safety planning
 - iv. Overall risk has decreased since admission
 - v. Family has identified informed supervisors to assist with supervision
 - vi. Appropriate aftercare services have been identified
- g. If family home is not available for discharge, then a lesser restrictive placement shall be considered.

6. Qualifications

- a. Therapists –
 - i. Service providers will only utilize professionals who are specifically trained through the Indiana Association for Juvenile Sex Offender Practitioners (IN-AJSOP), or an equivalent recognized credentialed authority.
 - ii. If a residential/group home clinician is in active status of CSAYC field instruction and under clinical supervision of an individual who possess CSAYC, the clinician is eligible to provide services.
 - iii. Staff members shall be knowledgeable of the dynamics surrounding child abuse/neglect, child and adult development, family dynamics, and community resources.
 - iv. Individual must be trained (post-secondary) in evidence based / promising practice trauma modality.
 - v. Any trauma based modalities must require **written approval from the DCS Central Office.**
- b. Case Managers
 - i. In addition to meeting requirements for 465 IAC 2-9-49, 465 IAC 2-11-49, or 465 IAC 2-12-49 Case Managers supervisors should be specifically trained as a CSAYP or equivalent
 - ii. Training can occur through the Indiana Association for Juvenile Sex Offender Practitioners (IN-AJSOP), or an equivalent recognized credentialed authority.
 - iii. Each agency should also have a sufficient number of case workers available to allow for a caseworker to child ratio of no more than 1-12 for private secure and child caring institutions and no more than 1-10 for group homes.
- c. Direct Care Workers
 - i. The ratio of direct care staff to children shall be 1:4 when the youth are awake for daily scheduled programs
 - ii. A ratio of 1:8 to 1:12 when youth are asleep to be approved by DCS. (must match safety and layout of program) (See policy section below)
 - iii. Group home ratio will be a minimum of 1:4 during awake hours and at least two direct care staff at night. If agency is operating with only one staff at night it must be approved by DCS residential licensing.
 - iv. In addition, to meeting training requirements as described in 465 IAC 2-9-54, 465 IAC 2-11-54 and/or 465 IAC 2-12-54 on-the-job competency evaluations of direct care staff

supervising sexual harmful youth should be completed by supervisors within the first 60 days of employment. Direct Care Staff competency is to be measured from agency specific programming and fidelity. Any identified deficiencies should be addressed through refresher training, supervisor coaching and/or counseling sessions within 30 days of the initial competency evaluation. Orientation training shall include, at a minimum:

1. Safety planning;
 2. Risk/needs/responsivity;
 3. Healthy relationships;
 4. Supervision/informed supervision and
 5. Sexual development
- v. Direct Care Staff training shall include population specific competency during orientation and at least annually by current CSAYC/CSAYP or equivalent recognized credentialed authority. Annual training shall include, at a minimum:
1. Safety planning;
 2. Risk/needs/responsivity;
 3. Healthy relationships;
 4. Supervision/informed supervision and
 5. Sexual development
- vi. Training is available through Indiana Association for Juvenile Sex Offender Practitioners (IN-AJSOP), or an equivalent recognized credentialed authority.

7. Additional Requirements and Policies

- a. Facility must have a policy on Admission/Exclusionary Criteria to include evaluation of level of risk and appropriateness for the current milieu.
- b. Room Assignment- The program must have procedures regarding supervision and room assignments (if youth are not in single rooms).
- c. The facility needs to have a policy and procedure regarding the use of alarms and video monitoring systems. Equipment is monitored through the facility environment of care rounds.
- d. The agency must provide a policy on regarding appropriate supervision of clients at all times to include sleep hours, school, and relief coverage.
- e. Facility will ensure that court and treatment recommendations are followed related to home visits, community passes and contact with victims.
- f. Facility must have a policy on appropriateness for community involvement on and off grounds specifically to address safety of the community.
- g. The agencies must have policies on what the agency considers appropriate boundaries for staff and youth interactions after youth is discharged from program.
- h. Agency must have a progressive improvement process (e.g. five-year plan) in place that demonstrates the clinical components are implemented consistently.