FORENSIC MENTAL HEALTH Association of California

Evidenced Based Practical Curriculum for the Treatment of Juveniles who have Sexually Offended (JwSO):

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Publications by Dr. Ralph

- "*Prosocial Treatment Models with Juveniles who Sexually Offend."* Perspectives, Fall, 2010.
- *"Prosocial Models of Treatment with Sexually Aggressive Youth." N. Ralph.* In B. Schwartz, Ed., The Sex Offender, Vol. 7, Civic Research Institute, 2012.
- *"Evidence-based Practice with Juveniles."* ATSA Forum, 2012.
- *"Competency Status and Juveniles with Pending Sexual Offense Charges."* Perspectives, 2012.
- *"A Prosocial Collaborative Model for Juveniles who Sexually Offend."* ATSA Forum, 2012.
- *"Guidelines for the Assessment and Treatment of Sexually Abusive Adolescents, CCOSO", 2013 (co-author).*
- *"A Follow Up Study of a Prosocial Intervention for Juveniles who Sexually Offend."* Sex Offender Treatment, 2015.
- "*A Longitudinal Study of Factors Predicting Outcomes in a Residential Program for Treating Juveniles Who Sexually Offend*." Sex Offender Treatment, 2015.
- *"An instrument for assessing prosocial reasoning in probation youth." Sex Offender Treatment, 2016.*
- *"Being a Pro: The Prosocial Model for Problem/Solving",* Safer Society Press, 2016.
- *"Moral Reasoning in Juveniles Who Sexually Offend". ATSA Forum, 2017.*
- *"Prosocial Treatment Methods for Juveniles who Sexually Offended." ATSA Forum, 2017.*
- "*A Validation Study of a Prosocial Reasoning Intervention for Juveniles Under Probation Supervision.* Sex Offender Treatment, 2017.
- "*Evidence-based practice for juveniles in 2017.*" Sexual Abuse (Blog), 2017.
- "*Practical Prosocial Methods for Assessment and Treatment of Juveniles with Sexual Offending Behaviors."* In *Sexually Abusive Behavior in Youth: A Handbook of Theory, Assessment, and Treatment*. B. Schwartz, Editor, Civic Research Institute, 2017.
- "*The Other Recidivi*sm." Sexual Abuse (Blog), 2019.
- *"Treatment Options and Outcomes for the Other Recidivism."* Sexual Abuse (Blog), 2019.
- "*The Utility of the JSORRAT-II*." NAPN Blog post. 2019.
- "*Neuropsychological and developmental factors in juvenile transfer hearings: prosocial perspectives*." Journal of Juvenile Law & Policy. 2019..
- "*A Replication of a Prosocial Reasoning Intervention for Juveniles*." Sex Offender Treatment. 2019.
- "*Developmental perspectives on "lying and manipulation" in juveniles who sexually offended*." Sexual Abuse (Blog), 2020.
- Most are available through my website as downloadable PDFs (norbertralph.com).

Terminology & Limitations of Presentation

- Term JwSO here refers to "juveniles who sexually offended", describes behavior, not the person. Terms and words matter. Don't want to call teens "sex offenders", since it implies a chronic pattern, etc., which doesn't reflect facts.
- Almost all research & presentation here is about male teens. About 5% of JwSO youth are females, and they are important.
- Some of the material and PPT's are from public domain materials or other sources. References if requested. Reasonably "fact-checked" but levels of evidence very.
- Do not take any clinical, legal, or other action based on this presentation. Use your usual sources of supervision and consultation.
- I do trainings b/c you all know so much and I learn from you all.

Limitations of Presentation

- Research by the author is presented and be aware of the “most beautiful baby in the world” effect.
- Some research here, including the author’s, is from small sample of convenience populations, and results need to be replicated.
- A goal of presentation is to make "fuzzy" concepts like evidenced-based practice, brain development, prosocial development & reasoning clear and usable.
- The presentation may be influenced by "confirmation bias" factors reflecting the presenter's perspectives, including his research on prosocial reasoning.
- Terms "prosocial" and "psychosocial" regarding maturity are used interchangeably.
- In this presentation tests, programs, & books are mentioned but neither the presenter or FMHAC are endorsing or have any financial interest or benefits directly or indirectly from any of these products.

Introduction

Surefire JwSO Treatment

- Focus on Both: 1. Best treatment for a particular youth (Case level), and 2. County management of this population w/ set practices/policies (County level).
- Collaboration Team: County level monthly staffing of case with:
- 1. Treatment provider.
- 2. PO's, and probation supervisor.
  - Designated POs with training and experience with this population.
- Family/Youth collaboration: Where possible collaboration w/ family/youth.
- Both the PO and treatment provider advocate for all of the above to promotes more effective treatment.

Surefire JwSO Treatment

- Treatment Providers: who collaborate with PO's regularly, use evidence-based, quality skill building and counseling methods, promoting prosocial skills and collaborative relationship where possible with the youth/family.
- Youth Change: Focus on moving youth from egocentric/impulsive motivated behavior to rule governed and prosocial functioning, with relevant tools and information. Relevant family changes also.
- Problem Redefinition: From a highly stigmatizing anxiogenic, amorphous narrative of problem, to a fact-based, well-defined problem with a realistic & optimistic outcome.
- Outcomes: Regular tracking of youth with dynamic assessment tool.

• Sexual offenses are among the most serious criminal offenses and victims injured, often children. Nonsexual offenses also create victims.
• Also, ~16%* JwSO victim of sexual abuse, ~31% physical abuse. *Population average.

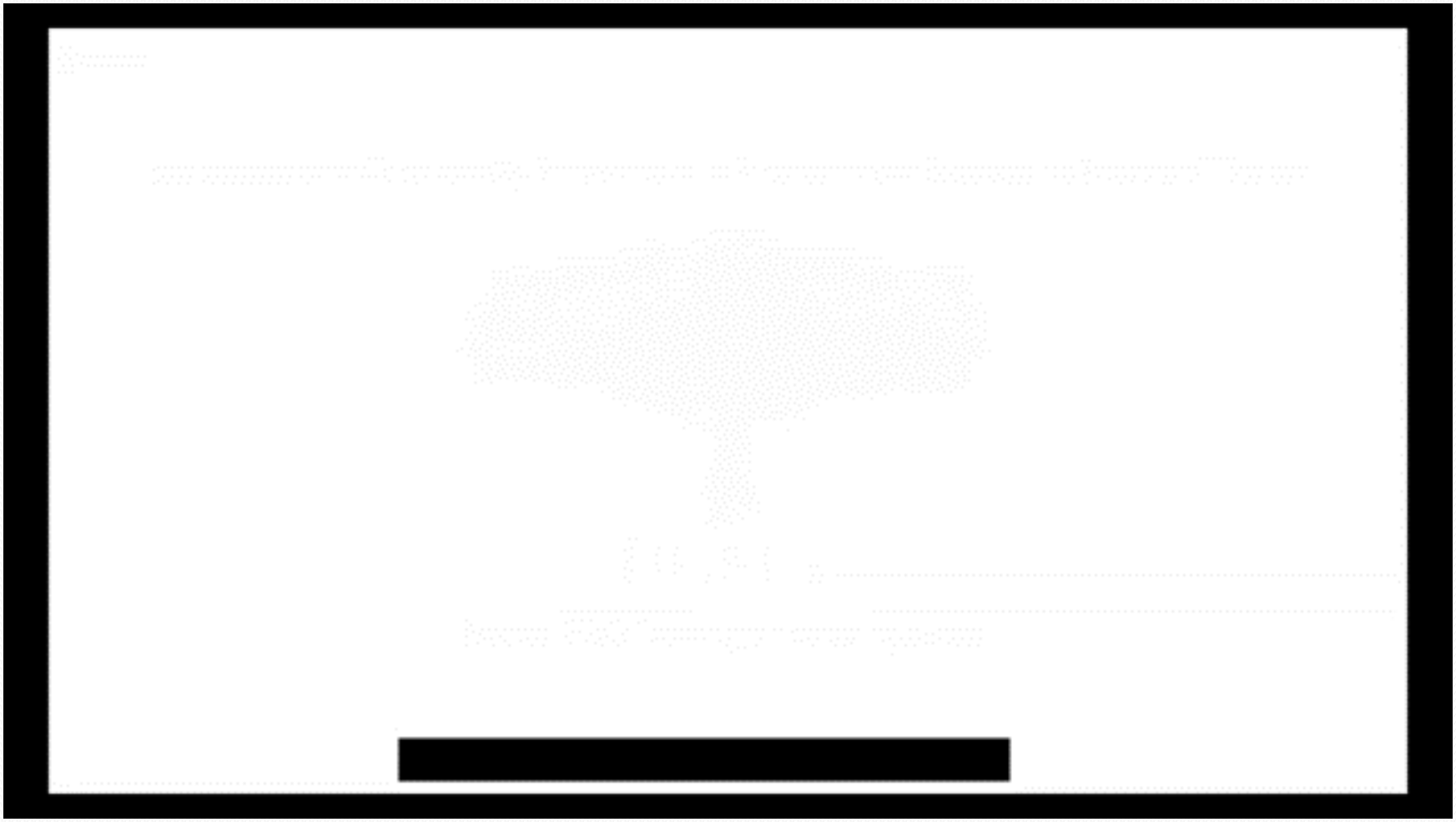
Honor Your Values & Reactions

- Your Values & Reactions to JwSO are important.
- While all crimes have a social stigma, sexual crimes violate social norms or taboos, and are considered among the most serious.
- Individuals may have reactions to JwSO's who have harmed children and others.
- These reactions will likely shape your actions with these youth and are important to recognize.
- For example, not all mental health clinicians want to work with this population and don't choose to do that. This may not be an option for PD's, DA's, PO's, and Detention Counselors.
- Please feel free to take timeout, or other measures that would be helpful for you. While material isn't likely to be triggering or traumatic, please take care of yourself in this regard.

National Center on the Sexual Behavior of Youth (NCSBY ncsby.org)

The National Center on the Sexual Behavior of Youth (NCSBY) is a part of the Center on Child Abuse and Neglect (CCAN) in the Department of Pediatrics of the University of Oklahoma Health Sciences. In 2001, CCAN was selected by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to establish NCSBY to develop resources and training material for professions from multiple disciplines (probation, mental health, medicine, education, child welfare, law, law enforcement, and the judiciary) addressing youth with problematic or illegal sexual behavior. As part of the initial three-year project, CCAN established NCSBY.org, a web-based resource center for professionals, and a National Advisory Board. The website included curriculum, cataloged assessment instruments, registration law information by states, and fact sheets.

National Center on the Sexual Behavior of Youth (NCSBY)



Caldwell 2016 Article

- Caldwell's (2016) article reported among other info recidivism rates since 2000.

- Found a weighted mean sexual recidivism rate since 2000 of **2.75%** for JSO youth, and any recidivism **30.00%.** (Note qualifications in article and by others).

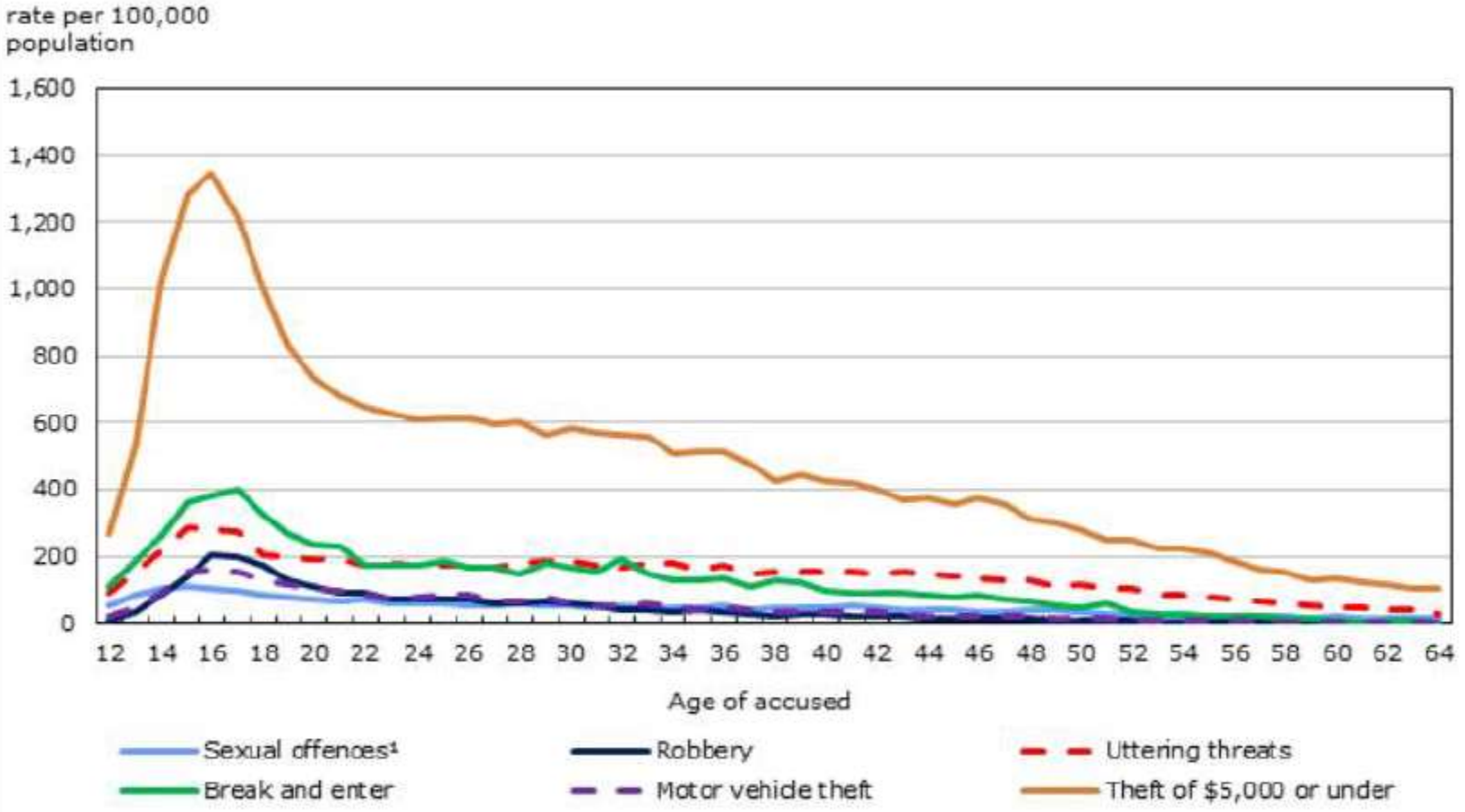
- Caldwell, M. F. (2016, July 18). Quantifying the Decline in Juvenile Sexual Recidivism Rates, Psychology, Public Policy, and Law. Advance online publication.

- 73% lower than the rate of 10.3% reported by studies conducted between 1980 and 1995.

- Follow-up for 36 months was adequate to identify recidivism and did not increase rates significantly.

Canadian Rates

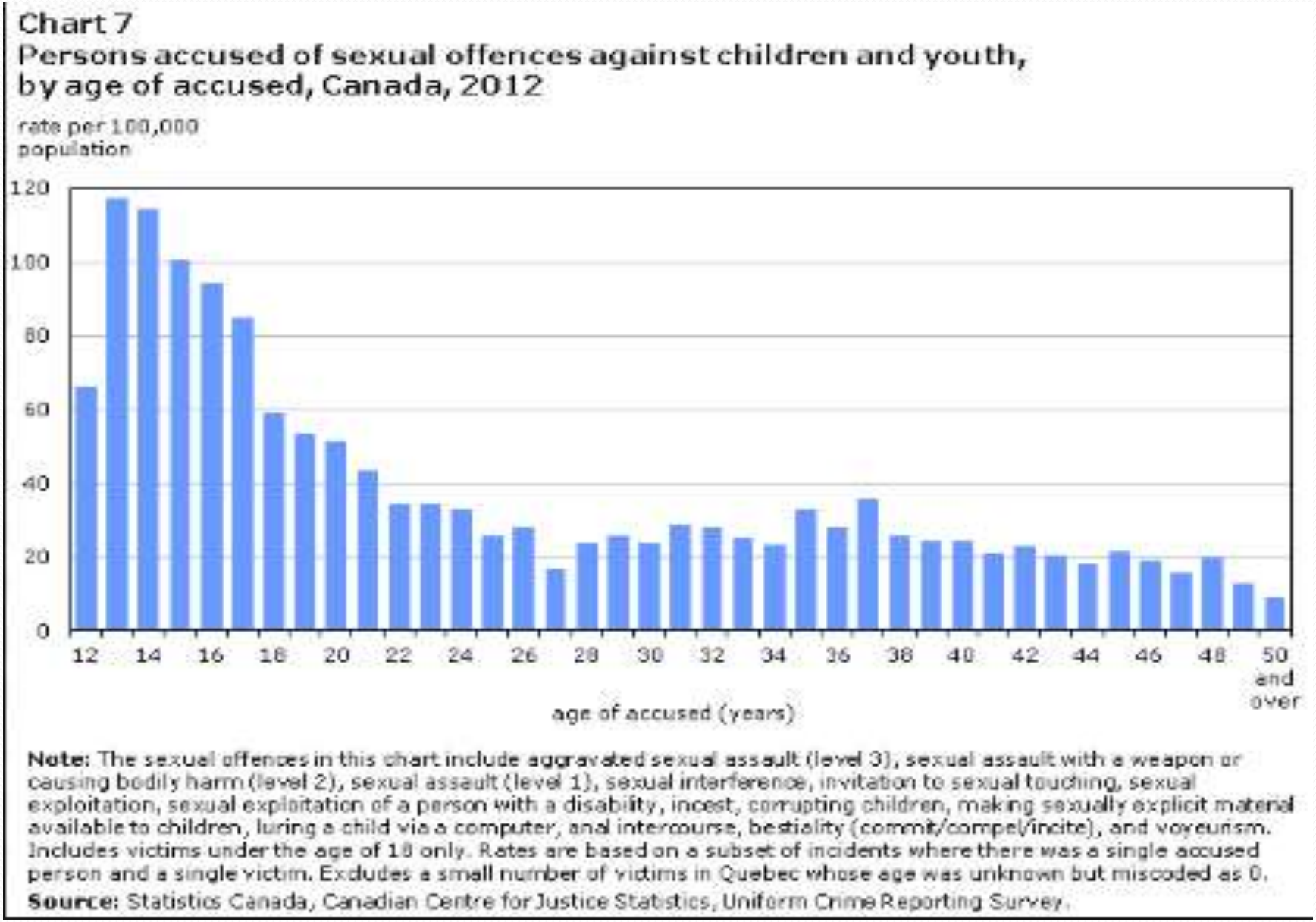
Chart 4
Selected offences which peak during youth and decline rapidly with age, 2014



1. Sexual offences include sexual assault (levels 1, 2, and 3) as well as sexual violations against children.
Note: Rates are calculated on the basis of 100,000 population at each age in 2014. Populations are based upon July 1st estimates from Statistics Canada, Demography Division. Accused under age 12 cannot be charged with an offence under the *Criminal Code*.
Source: Statistics Canada, Canadian Centre for Justice Statistics, Incident-based Uniform Crime Reporting Survey, 2014.

Figure 1: Canadian Sexual Age-Crime Curve, 2012

https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14008-eng.htm



Evidence-Based Treatment for JwSO

*b/c need best methods for best outcomes, incl. total recidivism

What Works for Me

- Doing outpatient JSR treatment, I've been lucky to have great POs & case managers.
- Have been able new cases where:
- I use curriculum that focuses on prosocial problem-solving, and other elements related to sexual offending.
- Close and cooperative communication and problem-solving with the PO regarding things like missed appointments and school/problems, etc.
- Case manager able to transport the youth to appointments, checking school and family, and collaborate with me and the parties.
- That's about as good as it gets, but also as described below, is consistent with "best practices" and what works the best.

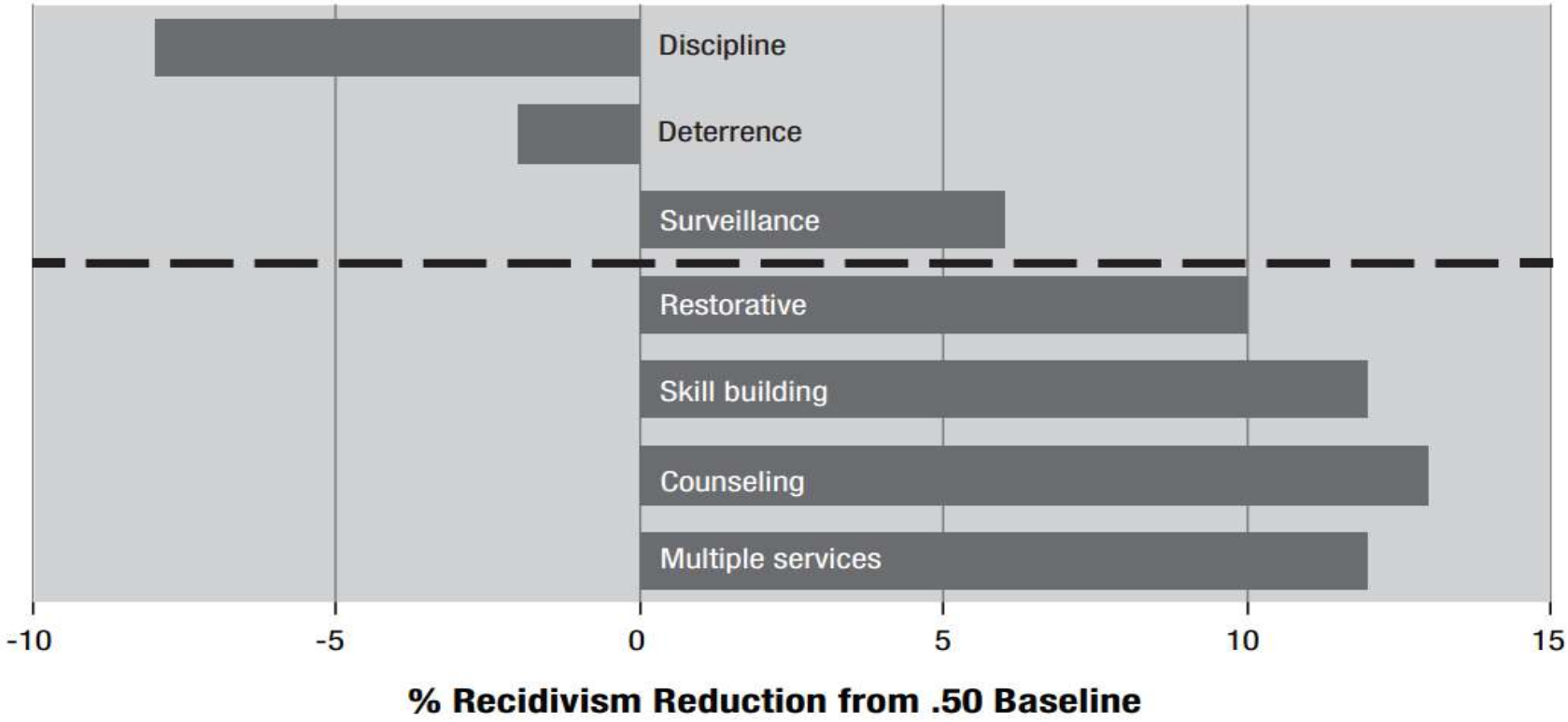
Evidence-based Treatment for Juveniles

- There is a significant body of work that has identified treatment approaches that promote favorable outcomes for juveniles on probation regarding reducing recidivism, increasing prosocial reasoning and moral maturity, and other positive outcomes.
- Lipsey (2009) used 548 different samples studying juvenile probation populations.
- Findings: Interventions with counseling or skill building were more effective than those based on control or coercion.
- Wrap-around & multiple services and rigorous probation supervision/ surveillance were effective.

Evidence-based Treatment for Juveniles

What is Effective for General Probation Youth?

Figure 1. Mean recidivism effects for the program categories representing control and therapeutic philosophies



What is Effective for General Probation Youth? Lipsey (2009)

- Age, gender, or ethnicity did not influence effectiveness.
- Interventions were more effective with youth with higher levels of delinquency.
- More effective if implemented with **high fidelity** and targeted at appropriate youth.
- Not only "**name-brand**", but locally developed "**Home Baked**" programs were effective. Both could be effective.
  - The key factor was are they well-designed, faithfully implemented, and targeted at appropriate youth.
- Separate research by Tennyson (2009) and Goense, et al. (2016) showed program fidelity for juvenile programs was strong associated with positive program outcomes. The better you followed the model, better outcomes.
  - Goense found a medium treatment effect when integrity was high ($d = 0.633$, $p < 0.001$), but no significant effect when integrity was low ($d = 0.143$, ns).

Evidence-based Program Characteristics (EBPC) Ralph, 2017

- Using Lipsey's research, and other studies, can describe a list of program characteristics associated with positive outcomes.
- Describes **characteristics** of programs, not a specific "Namebrand" program, and can rate both "Homebrew" and "Namebrand" programs.
- Evidence-based Program Characteristics (EBPC) described as follows.
- 1. The risk level and needs of the target population is assessed using reliable measures.
- 2. A treatment approach addresses the risk level and needs of the target population, and includes a sufficient amount of treatment to be effective.
- 3. The treatment approach uses social skill building, problem-solving, and counseling approaches.
- 4. The treatment method is manualized to reliably administer it.
- 5. Training and supervision is given regarding fidelity to the method.
- 6. Fidelity checks are "baked in" in and part of implementation of the method.
- 7. Reliable outcome pre/post measures are used to assess treatment effectiveness.
- The Prosocial Program incorporates these elements.

Is JwSO Treatment Effective?

- Kettry & Lipsey, 2018. Examined 8 high quality JwSO outcome studies.
- *"Remarkably little methodologically credible research has been conducted on specialized programs for JwSO's despite their prevalence. The best available evidence does not support a confident conclusion that they are more effective for reducing sexual recidivism than general treatment as usual in juvenile justice systems."*
- *"The fact that only a small proportion go on to commit further sexual offenses suggests that few of them are the kinds of specialist sex offenders who would be most likely to benefit from specialized treatment. If most of the JwSO-labeled youth who receive specialized treatment have low risk for further sex offenses to begin with, it is not surprising to find little or no overall effects on such offenses."*

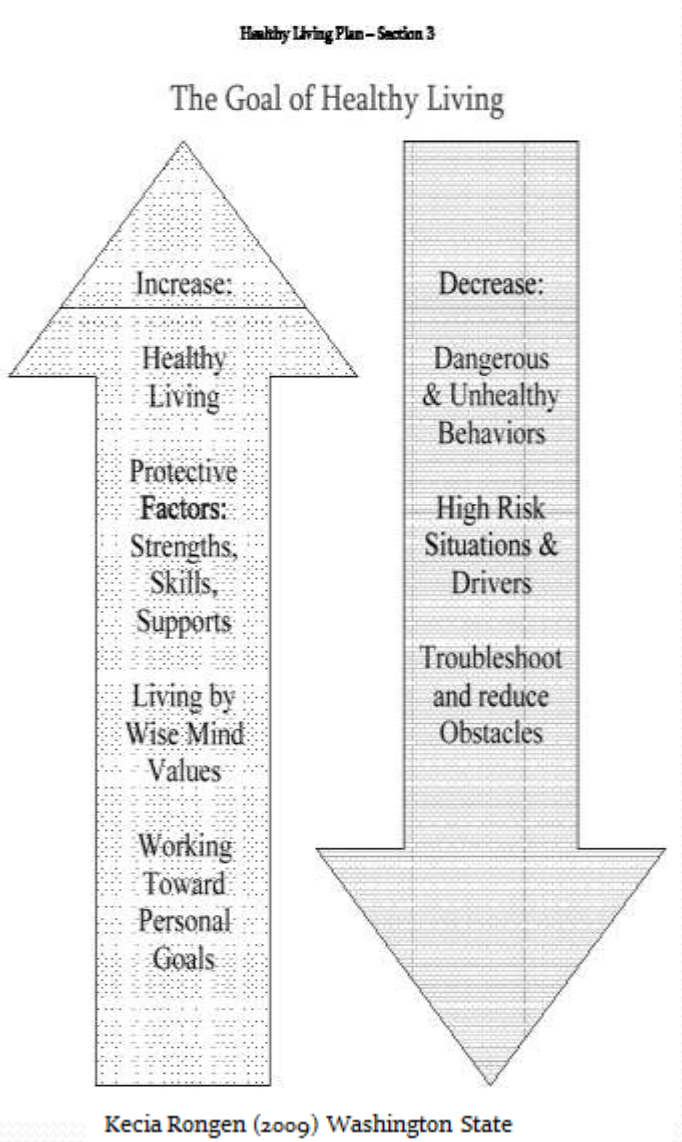
Is JwSO Treatment Effective?

- The treatment effect was even greater on general recidivism than sexual recidivism.
- *Pullman and Seto (2012) suggest that the majority of JwSO's are generalist offenders who happen to commit a sexual offense, whereas a small minority of JwSO's are specialist offenders with elevated risk for further sexual offending. The belief by many policymakers that all JwSO's are specialist offenders who pose a serious threat to the public (Becker and Hicks 2003) gives rise to the idea that specialized treatment is necessary to prevent JwSO's from committing future sexual offenses.*
- **An implication is that JwSO treatment should include "best practices" treatment for general recidivism described by Lipsey et al., including prosocial treatments addressing prosocial reasoning delays.**

Points & Programs for Evidence-Based Treatment for JwSO

JSR Collaborative Model

- JSR treatment has two foci:
- Relapse prevention; comorbidities, reduce risky situations and recidivism.
- Promote prosocial behaviors, strengths, future goals, and age-appropriate experiences.



Points So Far

- Okay Doc, so here is what we got so far about JwSO, right?
- Low recidivism sexual (~3%), higher total recidivism (~30%).
- ↑ Strengths & ↓Challenges, both.

- Assess & treat comorbid factors (psychiatric, learning, substance use, family, trauma/ACE, neighborhood, etc.).
- Family factors (MST: Low parental monitoring, high conflict, & low affection).
- Prosocial reasoning immaturity- ↑ prosocial reasoning.
- Effective programs (counseling, skill building, wraparound, strict surveillance/supervision), implemented with fidelity, targeting sexual & general recidivism.
- Prosocial counseling relationship and characteristics.

Points So Far

- Non-sexual re-offending key for JwSO b/c nonsexual offenses may create victims too. Tunnel vision sometimes w/ sexual offense.

- Other treatment needs key, e.g., substance abuse, PTSD, depressive conditions, anxiety conditions, ADHD, learning disabilities, educational failure, high risk sexual behaviors, etc.
  - Ability to make treatment/link for these areas.
- Cultural humility & sensitivity.
- Focus on school/academic functioning.
  - PD had MSW and lawyer for educational advocacy and case management.

Points So Far

- Okay, what else do we need?
- JwSO psychological assessment: Post-adjudication, pre-disposition, assessing total and sexual recidivism, comorbidities, family/youth collaboration/denial, comorbidities.

- County-based Collaborative Model. Different than the adult model which is the Containment Model.
  - Buy in from stakeholders: Probation, courts, PD, PO, DA, County mental health. All the parts need to agree to where possible work collaboratively as is appropriate for juvenile court and minimize where possible adversarial relations.
- Collaboration Team: Family/Youth, PO, Mental Health Provider.
- Small number of PO's who had training in the area supervising JwSO cases.
- Monthly case management with Supervising PO, Mental Health Providers, JwSO coordinator (myself). Problem solve, plan, collaborate.
- Cooperative with Case Management/linkage &/or educational advocacy.

Treatment team

- Treatment team: Licensed mental health professionals with ideally: Experience w/ counseling teens and families.
- Options: Providers from: 1. County Behavioral health, 2. CBO's/agencies, 3. Independent practitioners., or 4. Combos. Depends on results, but what works best in my experience was #1 with a little #2 or #3 added but they need to talk with PO.

- Funding: In my experience, best if no charge for services to families. It seemed to work the best.
- Provider model: Usual counseling has goal of "prosocial development" of youth, but forensic counseling requires inclusion of "community safety" and open communication with probation. Got to do both at once. May be a change for some.
- Treatment model needs to include aspects of evidence-based model, EBPC, described above, which are briefly:
  - Social skill building, problem-solving, set curriculum or workbook.
  - Training and supervision is given regarding fidelity to the method.
- Reliable outcome pre/post measures are used to assess treatment effectiveness.

Points So Far

- So we have done our due diligence of doing a good comprehensive assessment of the youth, we have a "buy-in" from probation, DA, and PD. So, what are we treating here?

- Buy-In & Definition: Helping the youth and family understand how the court and probation "define" the offense and problematic behaviors, and where possible, obtain collaboration regarding the definition of the problem, and measures to reduce recidivism and promote the prosocial development of the youth.
- Change the Definition: From a challenging, traumatizing, stigmatizing, ill-defined, and anxiety producing situation, to a clear definition, with a clear "fix" (getting through counseling & probation), possibly having charges sealed, with chance for prosocial life with no further problems. This journey can have a happier outcome.
- Comorbid psychiatric & Other Factors: Address any comorbid psychiatric, substance abuse, trauma, educational, gang-related, poverty, homelessness, etc. Develop appropriate interventions for these. These factors inhibit prosocial development of the youth, increase recidivism chances, and are treatable.

Points So Far

- Prosocial Development: Help transform youth from an Impulsive or Self-Protective level, to Conformist. From a stage where impulses and urges, or avoiding consequences, replaced by greater awareness of rules, laws, and If-Then and Ends-Means thinking.
  - Using Siegel's term, Gist, that is understanding the complexity of situations, information, including regarding consents, prosocial relationships, etc. Also understanding greater how adolescent physical, brain, and sexual development contributes to risky behaviors for adolescents, including sexually harmful behaviors. Being a Pro promotes prosocial reasoning skills to help youth "figure out" life problems better.

- Information: Giving the youth better understanding of their offense related to laws, the probation system, understanding of consents, physical growth, brain development and risky behavior, sexual drive characteristics.
- System goals: Helping stakeholders (PO, PD, DA, courts) have more accurate definition of the problem, prognosis, recidivism, and prospects for rehabilitation.

JwSO models & workbooks

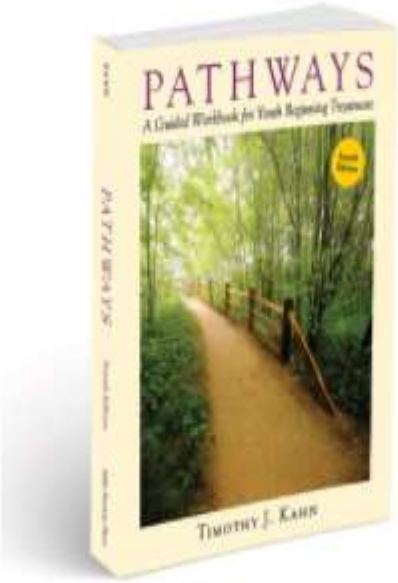
JwSO Treatment Models

- Multisystemic therapy: Multiple replications and adapted for JwSO. Ongoing fidelity monitoring, adjustment in real time to problem areas, perhaps 2 to 3 times a week for 4-6 months. Have to join the "franchise", start up and ongoing costs. Not adaptable to youth in detention.

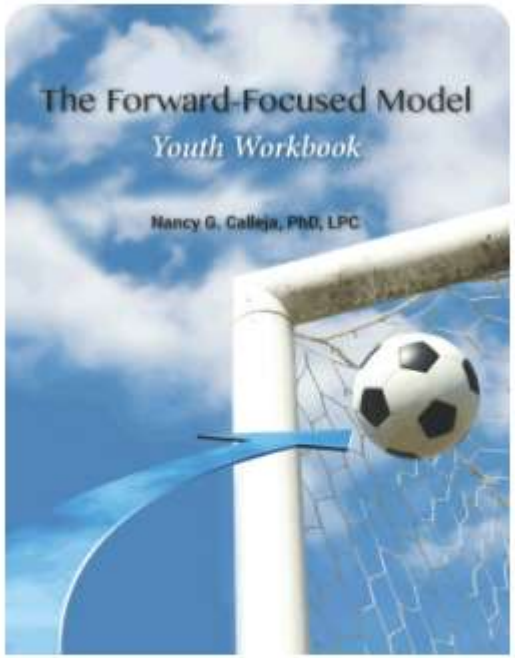
- Problematic Sexual Cognitive-Behavioral Therapy, University of Oklahoma Health Sciences Center. Implemented at multiple national sites, including LA County. Not a randomized trial, but significant support of research. A "franchise" system.
- University of Cincinnati, School of Criminal Justice hosted event. Dr. Paula Smith "I Decide: Cognitive Behavioral Intervention to Control Impulses and Create Identity for Adolescents".
  - 30 structured group sessions and three individual sessions. Designed to promote healthy sexual attitudes and behaviors, teach cognitive coping and social skills, enhance the capacity for perspective taking, improves emotional regulation, supports the formation of positive identity, and strengthens bonds with caregivers.

JwSO Workbooks-Safer Society Press

SET OF 4 STAGES OF ACCOMPLISHMENT WORKBOOKS



PATHWAYS, 4TH EDITION



FORWARD-FOCUSED MODEL WORKBOOK

Bake your Own!

- Just as good! Bake your own! That is what I did, see 23 Session Model below.
- Lipsey (2009) identifies that "Bake your Own" works as well as namebrand programs if well-designed, targeted, and implemented.
- More recent research (Baglivio et al. 2018) with residential probation programs found that the quality and fidelity the program was key.
- Also, w/ Total Recidivism 10x higher than Sexual Recidivism, are you targeting general delinquency in your model? Should be considered essential.
- Kettry & Lipsey (2018) that no significant evidence that specialized programs to treat sexual offending's are more effective than programs which target general recidivism.

Youth Needs & Progress Scale https://ncsby.org

Youth Needs and Progress Scale – Rating Form

Name: _____ ID #: _____ DOB: _____
1st Assess. ____ Re- Assess. ____ Discharge Assess. ____ No. of sessions this period: ____
Completed by: _____ Date: _____

Item	*No Intervention Need*	*Possible / Limited Intervention Need*	*Moderate Intervention Need*	*Strong Intervention Need*	*Unable to rate*
1. Understanding Appropriate Sexual Behavior	*0*	*1*	*2*	*3*	
2. Understanding the Consequences of Sexual Abuse	*0*	*1*	*2*	*3*	
3. Sexual Thoughts – Frequency	*0*	*1*	*2*	*3*	
4. Sexual Interests - Age & Consent	*0*	*1*	*2*	*3*	
5. Sexual Attitudes & Beliefs	*0*	*1*	*2*	*3*	
6. Sexual Behavior Management	*0*	*1*	*2*	*3*	
7. Compassion for Others	*0*	*1*	*2*	*3*	
8. Relationships with Peers	*0*	*1*	*2*	*3*	
9. Emotion Management	*0*	*1*	*2*	*3*	
10. Social Skills	*0*	*1*	*2*	*3*	
11. Self-confidence	*0*	*1*	*2*	*3*	
12. School & Work Commitment	*0*	*1*	*2*	*3*	
13. Use of Unstructured Time	*0*	*1*	*2*	*3*	
14. Nonsexual Behavior Attitudes and Beliefs	*0*	*1*	*2*	*3*	
15. Nonsexual Behavior Management	*0*	*1*	*2*	*3*	
16. Client View of Primary Caregiver Relationship	*0*	*1*	*2*	*3*	
17. Client View of Supportive Adult Relationships	*0*	*1*	*2*	*3*	
18. Family Functioning	*0*	*1*	*2*	*3*	
19. Living Situation - Safety & Stability	*0*	*1*	*2*	*3*	
20. Involvement in Community Resources	*0*	*1*	*2*	*3*	
21. Mental Health Management	*0*	*1*	*2*	*3*	
22. Participation in Interventions	*0*	*1*	*2*	*3*	
Tally ratings endorsed per column: (Number of 0's, 1's, 2's, 3's & unable to rate)					

Total Need Score: (Sum of all 1's, 2's, and 3's): _____

I-Decide Model
A CBT/Skill-building/Mindfulness Evidence-based program.

The I-Decide Program

- Is an evidence-based model for treatment of juveniles who sexually offended.
- It structure and content is consistent with what I described as above as EBPC.
- Outcome research with the model is pending and in process. Initial research looks favorable but not yet published in peer review journals.
- 30 sessions and three individual sessions which can be done once or twice a week.
- One to two group leaders.
- Can be adapted to individual and also telehealth sessions.

The I-Decide Program

- Cognitive Behavioral Therapy/CBT for I-Decide Model
  - Behavioral interventions
  - Cognitive Restructuring & Cognitive Coping Skills
  - Modeling & Structured Skill Building
  - Mindfulness, Motivational Interviewing & Relapse Prevention
- Similar to Aggression Replacement Training in terms of being a structured, curriculum heavy model, but in a workbook type easier to use format.

I-Decide: Risk-Needs-Responsivity Model

Risk	**Needs**	**Responsivity**
Level of services to address risk level.	What risk factors or "criminogenic needs" should be addressed.	Services adapted to characteristics of patient.
Use of assessment tools for sexual and nonsexual recidivism. Described as appropriate for youth with moderate to severe need for treatment.	Address deficits in knowledge, social skills, social problem-solving, relapse prevention, psychosexual education.	Adaptations of the model to patient's needs, but generally works well for most.

The I-Decide Program

- Session 1 Keep an Open Mind (and Participate)
- Session 2 Build Healthy Relationships
- Session 3 Define What Is Important to Me
- Session 4 Set Goals and Make a Plan (MAP)
- Session 5 Develop a Plan to Control Urges
- Session 6 Understand Life History and Lifestyle Factors
- Session 7 Identify Risky Situations
- Session 8 Pause and Breathe
- Session 9 Observe Thinking
- Session 10 Name Feeling

The I-Decide Program

- Session 11 Consider Purpose
- Session 12 Use Coping Strategies
- Session 13 Explore Core Beliefs About Relationships
- Session 14 Manage Emotions
- Session 15 Understand the Perspective of Others
- Session 16 Build Trust in Relationships
- Session 17 Set and Respect Boundaries
- Session 18 Build Healthy Peer Relationships
- Session 19 To Resolve Conflict with Others
- Session 20 Solve Problems

The I-Decide Program

- Session 21 Build Resilience
- Session 22 Engage in Healthy Sexual Behaviors
- Session 23 Say No
- Session 24 Express Interest and Ask Permission
- Session 25 Be Response-ABLE
- Session 26 E brace a Healthy Identity
- Session 27 Identify SUDS
- Session 28 Identify Social Supports and Ask for Help
- Session 29 Disclose Personal Information
- Session 30 Feel Good About Making Healthy Decisions

Steps & stages, and hurdles & helpers in treatment

Treatment challenges & facilitators

- **Distress of treatment** and dealing with issues related to probation and offending for parent and youth.
  - Worst is behind us, record will likely be sealed, all the conditions of probation (no drugs, school attendance, curfew, obtain parental rules, etc.) are desirable anyway.
  - "We are on the same page." Both parent, PO, and therapist want the youth to live a prosocial life without probation involvement. Support regarding the objective distress and limitations that probation entails but also there are benefits, case management, financial help, job options, educational advocacy, family counseling, etc.
- **Patient and family deny** any illegal sexual behavior occurred.
  - Directly address the issue in non-confrontive fashion, and explore +/- of admitting, not admitting, keep open the issue being admitted subsequently, can use most of curriculum. E.g., Imagine you had a cousin who committed similar crimes. How would you coach them to write an apology letter to victim, a relapse prevention plan, etc. Denial at beginning doesn't predict outcomes.

Treatment challenges & facilitators

- **Youth detained** on new, nonsexual issues, running away, other family challenges/deaths. Distraction and delay from completing JSR treatment. Provide treatment continuity in detention.
- **Youth not making appointments** because of forgetting, transportation problems, etc.
  - Coordination with parent, PO, and possibly case manager to facilitate making appointments. Use of Zoom options. The more sessions you missed the longer treatment takes.
- **Homelessness** or at risk, for older youth.
  - Working with the PO and public defender for options including extended family.
- **Acting out verbally aggressively towards female therapists.**
  - Limit setting by PO, and if no other options, transfer to male therapist.

Treatment challenges & facilitators

- **Parents/youth who are angry and don't want to participate.**
  - Being supportive, keeping the door open, counseling by PO and court, sometimes "moving on" without parent. Treatment can still work. Avoid getting into a tussle with parent.
- **LGBT youth:** I've only had a few. As with any youth, use "active listening" to be educated by them about their life and challenges. Be careful about using appropriate gender pronouns and assumptions about sexual interests and choices. Apologize for wrong assumptions and invite education. Apologies usually accepted.
- **Telehealth Treatment**: I adopted it immediately for pandemic. Found it works very well, but every youth and SF had a computer and Internet. Did screen share for curriculum, and had fewer missed appointments, and could see youth in their home environment. E.g.; one youth with kitten. Post pandemic I would favor three telehealth and one in person visit.

Questions from Participants?