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Final Report

Development and Implementation Project for the Youth Needs and Progress Scale (YNPS)

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Participating Sites

- Kentucky Department of Juvenile Justice
- Georgia Department of Juvenile Justice
- Oregon Youth Authority
- The Village Network
- Texas Juvenile Justice Department
- Clackamas County Juvenile Department
- Deschutes County Juvenile Community Justice

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Statement of the Problem

"Age-specific" legal structures began to appear in the U.S. around 1900, including compulsory education, child labor laws, and the juvenile court. In the earliest juvenile courts, the State assumed the duty to protect adolescents, acting on their behalf, providing them with care and intervention so that they could reform themselves and become civilized members of society. The process was not adversarial. The juvenile courts were acting for the children, not against them. Viewed as an exemplar of social virtue, the juvenile court's honeymoon was relatively brief. A multitude of weak assumptions led to a fall from grace (e.g., that clinicians knew how to properly evaluate the needs of troubled youth, that the prevailing science of the day knew how best to intervene with troubled youth, that the clinicians were properly educated, trained, and supervised, and that the Court could make informed decisions about how best to manage troubled youth). The "last straw" was the landmark case of *In re Gault*. Justice Fortas referred to Juvenile Courts as "kangaroo courts," characterized by "arbitrariness," "ineffectiveness," and an "appearance of injustice" (In re Gault, 387 U.S. 1 (1967)). Post-Gault reforms led to a "just desserts model of punishment," the same as existed in the adult courts (Reppucci, 1999, p. 314).

Within roughly twenty-years after Gault, disillusionment once again set in. Orlando and Crippen (1992) referred to "A Dangerous System," where "the problems Justice Fortas pointed to in 1966 continue today. Neither care nor due process is consistently given," (p. 95). In 1999, Reppucci observed, "The current "get tough" reforms that treat youths as adults are not consistent with the assumptions about age of maturity that are made in other regulatory domains," (p. 323). A second force at play, directed from the U.S. Supreme Court, sought to

rectify the denial of rights to juveniles waived to adult court that were guaranteed by the Bill of Rights and the Constitution to adults. Between these two powerful social forces, the light between juveniles and adults was ever dimming. Today, fifteen years after Reppucci's observation, while still paying homage

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to the legacy of Gault, we routinely implement management strategies (e.g., mandatory registration on public registries, in some cases lifetime registration, residency restrictions, in some cases for a lifetime, civil commitment in at least ten states) that are far more deleterious in their potential influence on the outcomes of the youth they impact than anything in the pre-Gault era.

During the past decade, however, the pendulum has once again begun to move slowly back in the opposite direction, principally in response to declining juvenile crime rates, the heterogeneity of delinquent populations, recognition that incarcerating juveniles may be yielding suboptimal results, and, most importantly, the impact of developmental neuroscience, and research on the juvenile brain (Bonnie & Scott, 2013; Dahl & Spear, 2004; Association for Psychological Science, 2013). These advances, however, have often not found receptivity in the juvenile courtroom.

Further, courts today are often provided evaluations that are not based on objective scientific evidence, with conclusions based on results that misinterpret – and occasionally flagrantly distort - the research, fail to address the limitations of the evaluation, and generally ignore practice guidelines (Zimring, 2004). Assessment of juveniles has, overwhelmingly, adopted a nomothetic focus on the presumptive risk of dangerousness rather than a comprehensive, idiographic assessment of the needs of the youth. Risk assessment, moreover, has become a mechanism for justifying denial of liberty and removal from caregivers and the community (Vitacco and colleagues, 2009). This is especially the case with adolescents who have committed sex offenses.

Assessing risk in the presence of developmental change introduces extraordinary uncertainty. Risk-taking, sensation-seeking, impulsivity, poor decision-making, illegal behaviors, and intense, unstable emotions are all normative in adolescence, not something idiosyncratic to delinquent youth. Although indisputably challenging, we must distinguish between what is normative and what constitutes a pattern of maladaptive, problematic behavior that is idiosyncratic to the youngster. Change must be

controlled for with: (a) repeated, short-term assessments and (b) change-sensitive markers that are built into the assessment. Assessing risk of adolescents is akin to hitting a moving target. Unlike adults, who typically present with decades of stable behavior patterns, adolescents and even young adults have very limited life experience and may offer little reliable evidence of a stable pattern that is useful for gauging risk. *What adolescents do exhibit reliably is unreliability.*

What happens to all adolescents in the normal course of development is further complicated by varying degrees of inappropriate, inadequate or even harmful interventions that many, if not most, juveniles with sex offenses have been subjected to. Abuse and neglect is often, moreover, real time (i.e., occurring within roughly the same time-frame as the risk assessment. Indeed, childhood abuse is well-known to be a robust, and some would argue universal, risk factor in antisocial behavior (Moffitt, Caspi, Rutter, & Silva, 2001). Further, home environment, multiple placements, caregivers, school, peers and other life situations of adolescents may change within a short timeframe. In sum, adverse early life experiences are "destabilizing" from the standpoint of assessing risk. Hence, the social ecology of youth may increase risk or be protective (Henggeler and his colleagues, 2009).

An interesting and important study in this regard examined age-related differences and dynamic risk factors in a large sample (n = 674) of adjudicated youthful offenders (Vincent, Perrault, Guy, & Gershenson, 2012). Vincent and her colleagues looked at SAVRY scores in three groups: <12, 13 – 15, 16 – 18). At follow-up (14.5 months average), group assignment by age did not moderate the association between SAVRY scores and re-offense. Dynamic risk factors, however, did increment predictive validity. Importantly, Vincent et al. (2012) found no evidence that age affected the zero-order correlation between SAVRY scores and the criterion (re-offense). Although the sample was not of juveniles with sex offenses, the findings are certainly noteworthy. Perhaps the most interesting question raised is the relation of dynamic risk factors, which did contribute to the explanatory variance, and age.

Presumably, there are some dynamic risk factors that are indeed highly age sensitive (e.g., placement / caregiver instability, substance abuse, social skills, social isolation versus social / peer involvement). Lastly, one might hypothesize that certain discrete subgroups of juveniles with sex offenses (i.e., the ones characterized by marked psychosocial immaturity that opportunistically target younger victims) would be more likely to evidence a moderating effect of age.

In sum, the risk "temperature" of adolescents is arguably far more variable and unstable than that of adults. The younger the child, the briefer the window of life experience from which to sample behavior (i.e., assess static risk) and the less stable and less reliable the fixed behavior that is sampled. Thus, the most important paradigm shift from risk assessment with adults (>25) to juveniles is a shift to a primary focus on capturing differing facets of dynamic risk (i.e., both acute and stable dynamic factors). Optimal assessment of this population must take into account the normative, pervasive developmental flux that defines this transitional period of juvenile's lives. Although capturing this flux is a significant methodological challenge, it is essential for improving the accuracy of our assessments, as well as improving our management decisions.

Risk-Need-Responsivity Model

A major theoretical advance that ties together an assessment of risk to the needs of the youngster and then ties those needs to the optimal (most responsive) interventions is the Risk-Need-Responsivity (RNR) model (cf. Andrews & Bonta, 2010). RNR has been implemented worldwide and reported on in the literature for decades. As stated, RNR is an integrative, unifying model that underscores the criticality of all phases: comprehensive assessment of needs as well as risk, evaluation-driven intervention plans and all other client-specific interventions, and the "responsivity interface" between "needs" and interventions. Programs that apply RNR principles of effective intervention have greater reductions in criminal recidivism among both adults (Andrews & Bonta, 2010) and juveniles (e.g.,

Pealer & Latessa, 2004), including adults and juveniles who have committed sexual offenses (Hanson et al., 2009). To be most useful, and consistent with the RNR Model, assessments of adolescents who have sexually offended consider factors associated with sexual and non-sexual reoffending by either increasing the likelihood of reoffending (risk factors) or mitigating the risk (protective factors). This consideration does not focus only on individual (ontogenic) factors; but extends to family (microsystemic), community (exosystemic), and cultural (macrosystemic) factors as well. Although historical factors that are associated with recidivism or desistence (i.e., static risk factors) may be useful for assessing risk, identifying dynamic risk and protective factors (i.e. criminogenic needs) are essential, as they alone are primary targets for intervention.

Additionally, depending on the youth, there are special issues that may require assessment, because they either are related to the offending, intervention priorities or facilitating intervention responsiveness. Such factors may include substance abuse, trauma symptoms, cognitive functioning and serious mental health issues. Similarly, socio-ecological factors that can affect service delivery and intervention responsiveness must be considered, e.g., caregivers' willingness to actively supervise the youth or be involved in his or her intervention, school and community sentiment and response, cultural practices and beliefs. By considering these varied factors, the Risk–Need–Responsivity model can provide a road map for effective interventions.

Extant Measures of Risk for Juveniles with Sex Offenses

This Statement of the Problem will not delve into a review of the extant literature on risk assessment of juvenile with sex offenses. The literature has been reviewed numerous times (e.g., Prentky, Righthand, & Lamade, 2015; Rich, 2014; Viljoen, Mordell, & Beneteau, 2012; Vitacco, Caldwell, Ryba, Malesky, & Kurus, 2009; Worling and Langstrom, 2003). In brief, development and testing of risk scales for these juveniles began in some earnest in the mid-1990s, with the first scale

reaching publication in 2000 (Prentky, Harris, Frizzell, & Righthand, 2000). A 2010 survey reported that two risk assessment scales, the ERASOR (Worling & Curwen, 2001) and the J-SOAP-II (Prentky & Righthand, 2003) were currently used by more than half of all outpatient and residential intervention providers in the U.S. (McGrath, Cummings, Burchard, Zeoli & Ellerby, 2010). Dr. Worling (2017) has recently developed the Protective + Risk Observations for Eliminating Sexual Offense Recidivism (PROFESOR, www.profesor.ca) in lieu of the ERASOR. The PROFESOR includes 20 "bipolar" items, each rated as "Protective," "Neutral" or "Risk." There are, however, numerous other similar measures that are presently in use (e.g., J-SORRAT-II, Epperson, Ralston, Fowers, DeWitt, & Gore, 2006; JRAS, Hiscox, Witt, & Haran, 2007).

In contrast to previous risk assessment research, this project addresses the critical need to (1) develop a dynamic intervention needs and progress scale to assist service providers in identifying risk relevant intervention needs, (2) develop individualized, responsive intervention plans, and (3) monitor progress in response to effective interventions. To this end, we began this project with a literature review of factors associated with the onset, persistence, and desistance from sexual and nonsexual offending among male and female adolescent and adult populations. We also reviewed items included in some of the juvenile risk assessment scales that have been most subjected to empirical scrutiny, and considered dynamic items that appeared promising. For example, we reviewed the Assessment, Intervention, and Moving-on Project (AIM-2) (Griffin, Beech, Print, Bradshaw & Quayle, 2008) and Griffin et al. (2008)'s study. This study provided support for Bremer's (2006) assessment model of integrating risk and protective factors to identify relevant intervention targets and guide effective interventions. In this study the authors describe the development of the "draft" AIM-2, a holistic research-based structured assessment guide designed for males, ages 12 through 18 years, who have sexually abused others. The AIM-2 included 75 static and dynamic individual, family or caregiver and environmental factors and are

scored as “concerns” (risk factors) or “strengths” (protective factors) and categorized as low, medium or high on each domain. The predictive validity of the AIM-2 was tested with a randomly selected subsample of 70 adolescents who were followed for a minimum of two years (average follow-up of 6 years). Findings indicated 10% or 7 adolescents committed a new sexual offense. All of the sexual recidivists had high “concern ratings” (i.e., risk factors) and low “strengths” (i.e., protective factors). Further, subjects with high concern ratings, but who had high protective ratings were less likely to reoffend than those with similar concern ratings but little strengths, suggesting that a cumulative effect of multiple protective factors may reduce the likelihood of repeat offending.

Risk and Interventions: Good Assessments Guide Effective Interventions

There is a frequent “disconnect” between assessment and interventions in RNR programs (DeMatteo, Hunt, Batastini, & LaDuke, 2010). As DeMatteo et al. noted, “there is often a weak link between the assessment of risk and the selection of needs-appropriate intervention strategies for specific offender populations. This disconnect can reduce the likelihood of achieving optimal or even minimal reductions in re-offense rates,” (p. 62). There is, moreover, a tendency for clinicians conducting assessments to identify needs that are unrelated to risk and fail to identify needs that are related to risk (Borum, 2003; DeMatteo et al., 2010). The principle reason for targeting non-criminogenic needs is that, clinically, they appear very compelling. Enhancing self-esteem, as DeMatteo et al. (2010) pointed out, may be laudable, but it is unlikely to mitigate risk of re-offense.

Although little is known about protective factors that are unique to juveniles who have committed sex offenses, ATSA (2012) pointed out possible candidates from the delinquency literature, including positive family functioning (e.g., adequate supervision, consistent and fair discipline), positive peer social group, supportive adults, commitment to school, pro-social / non-criminogenic attitudes, and emotional maturity. Many of these, as Stattin and Magnusson (1996) suggested, are simply the inverse

of risk factors (e.g., positive peer social group, pro-social / non-criminogenic attitudes). Overall, research on protective factors and sexual reoffending has been minimal. Yet, extant research regarding general offending and resilience following adversity, such as child abuse and neglect, (e.g., Cicchetti & Toth, 2009) suggests that the presence of protective factors, especially multiple ones, may have a moderating or buffering effects on risk factors associated with sexual and nonsexual recidivism. Thus, identifying individualized empirically-supported risk-relevant targets for intervention optimizes risk mitigation, thereby reducing the likelihood of recidivism *of any kind* and promoting prosocial lifestyles. In sum, good assessments guide effective interventions are those that provide the most intensive interventions to those with the greatest needs and fewest protective factors, are assessment driven, match interventions to relevant criminogenic and responsivity needs, are based on the best available evidence, and are applied with fidelity to the intervention model.

Project Goals

The project had five goals:

(1) Develop and test an evidence-informed Youth Needs and Progress Scale (hereafter referred to as YNPS) for assessing – primarily - dynamic risk and protective factors and limited 'experimental' historical items empirically associated with sexual and nonsexual reoffending by juveniles with sex offenses (JSOs) and identifying related intervention needs associated with those factors;

(2) Develop a user-friendly data entry software program that enables evaluators to rate risk-relevant factors in their initial assessments and reassessments so they can design intervention or case management plans accordingly, monitor progress, and assess readiness for discharge via periodic reassessments;

(3) Test the scale with 300-500 youth at multiple sites across the U.S. and examine reliability and validity of the YNPS items, for example, by analyzing comparisons of scores on the YNPS with deidentified, electronic, routinely collected data reflecting the juveniles' overall functioning prior to and during the course of intervention;

(4) Revise the scale accordingly to produce a final version of the YNPS and revise the data entry program; and

(5) Provide sites with training on the final version of the YNPS, including a train-the-trainers component that can promote sustainability.

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Goal 1: Scale Development and Methods

<u>Goal #1</u>: Develop a rationally derived list of dynamic risk and protective factors that could potentially correspond to intervention needs and goals for juveniles with sexual offenses.

The first goal of the project was to develop an empirically derived list of dynamic risk and protective factors associated with sexual and nonsexual offending.

Step 1, We conducted an exhaustive review of the empirical literature (e.g., Heilbrun (Ed.), 2017; Righthand, Baird, Way, & Seto, 2014; Righthand & Murphy, 2017), and nonsexual offending (e.g., Bonta & Andrews, 2017, Hoge, 2016) and reviewed the items, factors, and domains included on multiple assessment scales developed for juveniles with sexual offenses (e.g., AIM-2, ERASOR 2.0, J-RAT, J-SOAP-II, J-SORRAT-II, VRS:YSO) and scales developed for youth with nonsexual offenses (e.g., YLS-CMI, SAVRY, START:AV, PSL:YV, OYAS).

Although we primarily focused on dynamic risk and protective factor items associated with youth who have sexually offended, we also considered items and measures relevant to general delinquency and violence because most juveniles with sex offenses are likely to reoffend with a nonsexual offense, if they re-offend at all (i.e., the known sexual recidivism rates are consistently low, ranging from 5%-15%; e.g., Caldwell, 2010; Heilbrun, et al., 2005; McCann & Lussier, 2008; Reitzel & Carbonell, 2006; Viljoen, Mordell, & Beneteau, 2012). We also reviewed historical items and explored how they may be redesigned and included dynamically, if appropriate.

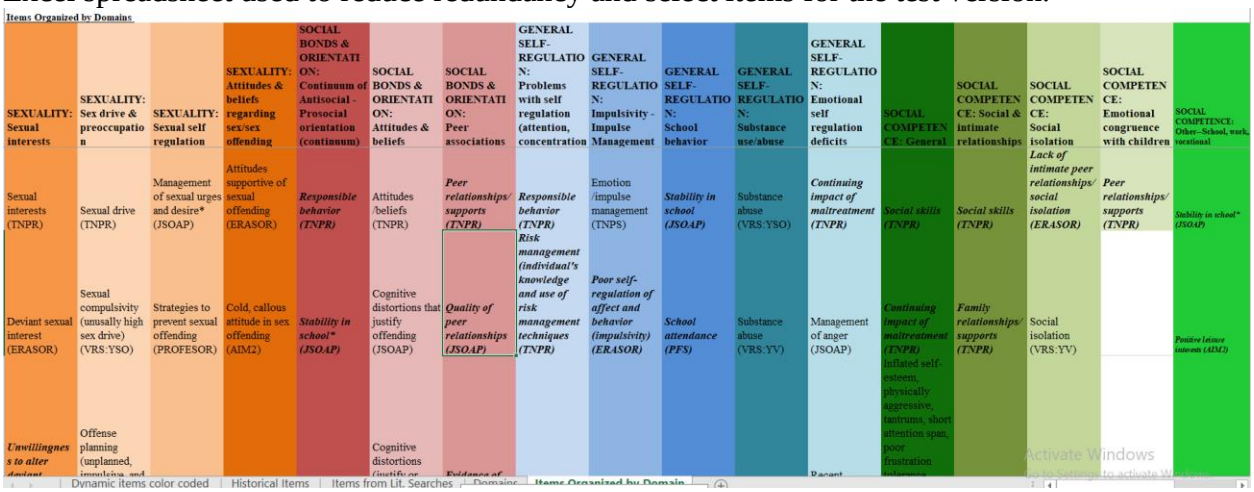
Table 1. Examples of assessment scales reviewed for the development of the YNPS test version.

Juvenile Sex Offender Assessment Protocol-II (J-SOAP II; Prentky & Righthand, 2005)	**Estimated Risk of Adolescent Sex Offense Recidivism 2.0** (ERASOR 2.0; Worling & Curwen, 2002)	**Intervention Needs & Progress Report** (TNPR; Righthand, 2005)
AIM2 (Griffin, Beech, Print, Bradshaw, & Quayle, 2008) (Dis-criminating items)	**Desistence for Adolescents who Sexually Harm** (DASH; Worling, 2013)	**Protective Factors Scale** (PFS; Bremer, 2005)
Protective + Risk Observations for Eliminating Sexual Offense Recidivism (PROFESOR; Worling, 2017)	**Juvenile Risk Assessment Tool** (J-RAT; Rich, 2000-2017) (only dynamic protective factors listed)	**Violence Risk Scale: Youth Sexual Offender Version** (VRS:YSO; Wong, Olver, Nicholaichuk, & Gordon, 2003)
Violence Risk Scale-Youth Version (VRS-YV; Wong, Lewis, Stockdale, & Gordon, 2004-2011)	**Structured Assessment of Protective Factors for Violence Risk** (SAPROF; de Vogel, de Ruiter, Bouman, & de Vries Robbe, 2009, 2012)	**Risk & Needs Inventory-TV** (RNI; Prentky & Righthand, 2017)
Short-Term Assessment of Risk & Treatability: Adolescent Version (START:AV; Viljoen, Nicholls, Cruise, Desmarais, & Webster)	**The Youth Level of Service/Case Management Inventory** (YLS-CMI; Hoge & Andrews, 1996)	**Structured Assessment of Violence Risk in Youth** (SAVRY; Borum, Bartel, & Forth, 2002)
Psychopathy Check List-Youth Version (PCL-YV; Forth, Kosson, & Hare, 2003)	**Ohio Youth Assessment** (OYAS; Latessa, Lovins, & Ostrowski, 2009)	
Also reviewed the literature pertaining to protective factors, examples include: • Robbe, Mann, Maruna, & Thorton, 2015: 8 protective factors • Losel & Farrington, 2012: Protective factors in the development of youth violence • Woldgabreal, Day, & Ward, 2016: Linking positive psychology to offender supervision outcomes • Epstein, 2004: Behavior & Emotional Rating Scale (BERS-2)		

Step 2, Using the Microsoft Excel application, potential risk and protective factors were translated into a series of detailed Excel tables. The Excel tables were independently reviewed by members of the project's 'core team' (Prentky, Righthand, Worling, and Kang). Each member of the

core team used empirical evidence, theory, and/or clinical experience to create independent lists of 50-60 dynamic risk and protective factors deemed important to consider during interventions to promote better management of youth who have sexually offended and reduce the likelihood of recidivism. The Project Manager and the Co-Principle Investigator reduced redundancy among the lists and documented overlap among the four independently created lists. See Figure 1 for an example of the excel spreadsheet created to help the core team reduce redundancy and select promising intervention needs.

Figure 1. Reduction of redundancy
Excel spreadsheet used to reduce redundancy and select items for the test version.



We next developed criteria for reducing the number of risk and protective factors. If 4 of the 4 members of the core team listed the factor as important, the factor was added to the list. If 3 core team members listed the factor as important, the core team met to discuss the relevant empirical, theoretical, or clinical significance of the item in order to come to a final consensus on whether including the factor was necessary. Using this procedure, we finalized a list of 54 dynamic factors and 27 historical factors. See Table 2 for one of the many iterations of lists of factors considered.

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Table 2. List of factors considered
**Items the Core Team agreed upon highlighted in yellow
**Majority in agreement on item

Individual Factors

Sexuality

1. Sexual attitudes, beliefs & values regarding sexual misconduct/abuse
2. Sexual interests (e.g., young children, violence, healthy)
    a. Interests in age appropriate sexual objects
3. Sexual knowledge OR Lack of knowledge of laws and procedures regarding consenting sexual behavior (e.g., personal boundaries, physical space, relational norms, etc.)
    a. Classification groups-developmentally immature kids
    b. Consent
4. Sex drive/sexual preoccupation/balanced degree of sexual interest/frequency
5. Sexual regulation/management/sexual urge management (skills)
6. Sexual responsibility (locus of control, assumes responsibility for all sexual behavior)

Personal response to sexual offending

7. Shame connected to past sexual offending
8. Guilt/remorse connected to past sexual offending
9. Fear of personal consequences
10. Awareness OR Lack of awareness of victim impact/victim empathy

Peers

11. Peer influences/affiliation w/ antisocial peer group (prosocial-antisocial spectrum; delinquent)
12. Friends or acquaintances who endorse abuse-supportive attitudes

Attitudes/beliefs/cognitions

13. Social orientation (anti—pro) (overall: attitudes [prosocial OR criminogenic], values, emotions, attachments, behavior; delinquent)
14. Attitudes, beliefs, & values regarding criminal behavior (delinquent)
15. Criminal thinking

Conduct

16. Rule adherence/conduct (general)
17. Relationship with authority
18. Delinquency/criminality-law abiding (general)
19. Good OR poor emotional self-regulation (expression & skills for management)
20. Good OR poor behavioral/general self-regulation (what is expressed & skills—ability to focus, manage impulses, passivity, activation; delinquent)
21. Behavioral impulsivity (e.g., impulse control/self-control; delinquent)
22. Risk taking/sensation seeking (range)
23. Pathological lying/manipulative/conning/parasitic

Skills/strategies to prevent reoffending

24. Knowledge/awareness & use of risk management/sexual-prevention strategies

25. Substance abuse
26. Stress management skills/coping with stress/adverse life events
27. Conflict management skills

Caring/compassion
28. Callous/uncaring towards others OR Compassion and caring/General empathy/perspective taking

Free time constructive use of time
30. Engagement OR Lack of involvement in structured leisure activities
31. Use of free (leisure) time
32. Positive talents/interests

Quality of peer relationships
33. Intimate peer relationships/close friendships
34. Age appropriate friendships & emotional intimacy skills
35. Peer rejection

Social skills/Competence
36. Basic social skills/social competence (e.g., eye contact, physical boundaries; social ineptness) Dating skills (as appropriate, expressing interest, ensuring consent, managing rejection), Communication skills (developing/maintaining friendships, active listening)
37. Social immaturity
38. Good OR Poor problem-solving & decision-making skills

39. Ability to learn from mistakes and feedback

40. Commitment to/engagement in school or work
41. Self-worth: Believing in yourself—Self-image/self-esteem (poor, inflated—positive/healthy)/ Self-efficacy, agency

Malintervention
42. Current impact of inappropriate or harmful interventions for sexual victimization
43. Nature and extent of morbidity associated with abuse

Personal attachments
44. Attachments to others/support systems (impersonal, little concern, "weak ties," asocial, social life social isolation—strong connections, at least one emotional confidant, evidence of positive support systems, strong attachments and bonds, strong social support; social ineptness)
45. Emotional identification with young children
46. Child—Quality of parent relationship (mother/father) (child perspective)
47. Relationship w/ family members (positive-negative/prosocial-antisocial/quality)
48. Strong commitment to a prosocial organization (e.g., church, school, team, etc.)

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Sexual outlets
49. Age appropriate, healthy, legal relationships/interests with same age peers
50. Rewarding, consenting relationship(s) with a peer

Future Orientation
51. Future orientation (plans, goals, hope)
52. Hopefulness regarding healthy sexual future
53. Motivation to change

Interventions
54. Responsive to OR Actively resists interventions/Intervention engagement
55. Intervention progress/completion/maintenance of gains
56. Sibling abuse interventions (clarifications, reunification, reintegration)
57. Evaluations from staff

Environmental Factors

Family/Parent(s)/Caregiver relationship (family/caregiver perspective)
58. Child—parent relationship (father/mother; e.g., caring, supportive, rejecting, antagonistic)
59. Caregiver response to sexual misconduct (parent rejection—supports child)
60. Parental involvement/support in interventions
61. Caregiver personal challenges (e.g., substance abuse, personal trauma, sequel; abuse reactive)
62. Parent management skills
63. Parents/caregivers who endorse abuse-supportive attitudes
64. Caregiver/family social orientation (prosocial—antisocial)
65. Social "ecological"/environment/child rearing: protracted/invasive abuse (abuse reactive)

Living situation
73. Return home/victim in home/neighborhood situation (risky/supportive)
74. Stable and secure living environment (separate from family/steps toward integration)
75. Abuse-supportive attitudes in living environment/Sexualized living situation
76. Placement instability (abuse reactive)
77. Stable/High stress family environment (abuse reactive)

Community
78. Environmental influences (extended family, neighborhood, community)
79. Significant community violence/crime
80. Community support network (gangs—positive)
81. Severe legal/social policy consequences (e.g., public registration)
82. Rehabilitation services available/uses services (e.g., recommended intervention [may include med management and adherence], education, vocation)
83. Environmental controls/supports (supervision, transportation & other needed resources)
84. Adequate external monitoring
85. Available emotional supports
86. Supportive relationship with positive/supportive/caring adult support, mentors, role models (negative—positive)/positive attitudes from significant adults)

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Step 3, Next, we developed the rating scale to 'operationalize / measure' each risk or protective factor or intervention response need item. We reviewed rating scales from assessment scales used with juveniles who have sexually offended and the extant literature on reliable rating scales in order to balance reliability of ratings, without truncating the rating system into the commonly used 3-point scale used for most assessment scales. Our goal was to create a rating scale that was reliable but also was able to better capture subtler changes along the continuum of risk and protective factors. Table 3 provides examples of the rating scales we reviewed and considered.

After adopting a 4-point ordinal rating scheme, each member of the core team was assigned items to operationalize into the 4-point scale. We experimented with a variety of different "templates," reviewing the strengths and limitations of each approach and their likely impact on the validity and reliability of the ratings and finally decided upon a template for the rating scale. With the agreed upon template in hand, the four members of the core team divided up the 54 dynamic items and applied the rating template to each.

Step 4, To further reduce the number of items on the test version of the scale, we requested feedback from a 7-member Advisory Board that consisted of researchers and clinical psychologists with expertise in assessment of juveniles who have sexually offended. To standardize the feedback received from the Advisory Board, we developed a fillable PDF to guide our Advisory Board members in rating each potential factor on:

(a) the importance of the item (drop, maybe, keep),

(b) level of empirical support in predicting sexual recidivism (none, some, strong),

(c) relevance by age and gender,

(d) relevance for noncontact vs. contact offenses, and

(e) a space for qualitative comments was provided.

Table 3. Scoring/Rating Scales

Scale 1:	0 1 2 (Static & Dynamic: JRAS, J-SOAP-II, AIM-2, All dynamic: JSO Progress Scale [TNPR], RNI [no/minimal need, moderate need, significant need])
Scale 2:	-1 0 +1
Scale 3:	-2 -1 0 +1 +2
Scale 4:	Yes/No (0/1) (J-SORRAT, ODYS, DASH)
Scale 5:	0 1 2 3 (VRS-YSO, PFS, SOTIPS, TPI-ASA [no evidence, 1 time, 2 times, 3 or more times])
Scale 6:	Strengths: High Moderate Low Vulnerabilities: Low Moderate High Critical Item (START-AV)
Scale 7:	Protective Neutral Risk (PROFESOR)
Scale 8:	1 2 3 4 5 6 7 8 9 10 None Some Full responsibility (ODYS)
Scale 9:	0 Highly unlikely 1 Somewhat unlikely 2 Somewhat likely 3 Highly likely 4 Not applicable (ODYS)
Scale 10:	0 A lot of Problems 1 Some Problems 2 Slight Problems 3 No Problems (ODYS)
Scale 11:	All Most Some None (ODYS)
Scale 12:	Low Moderate High (SAVRY)
Scale 13:	Present/Absent (SAVRY)
Scale 14:	Present Partially/Possibly Present Not Present Unknown (ERASOR)
Scale 15:	Concerns score OR strength score High concerns Concerns Low concerns High strengths Strengths Low Strengths (AIMS-2)

Step 5, Seven Advisory Board members and four core team members filled out the PDF (total $N = 11$), and the PDFs included independent ratings on:

(a) importance in assessing risk-related intervention needs (drop, maybe, keep),

(b) level of empirical support (none, some, strong),

(c) relevance by age (10-14, 15-17, 18-25), gender (males, females, cannot say), and contact vs. noncontact offending.

See Figures 2 and 3 for examples of the survey created for the Advisory Board.

Figure 2. Example #1 of the survey created for the Advisory Board.

Part I: Dynamic Items for Consideration

1. **Attitudes & beliefs regarding problematic sexual behavior**
   - (+2) Respectful and age-appropriate sexual beliefs/attitudes
   - (-2) Abuse-supportive sexual beliefs and attitudes

Importance of item	Level of empirical support	Possible relevance by age group and gender (select all that apply)		Possible relevance for (select all that apply)	Comments
☐Drop ☐Maybe ☐Keep	☐None ☐Some ☐Strong	☐10-14 ☐15-17 ☐18-25	☐Females ☐Males ☐Cannot say	☐Noncontact offenses ☐Contact offenses	

7. **Problematic sexual behavior against stranger**

Importance of item	Level of empirical support	Possible relevance by age and gender group (select all that apply)		Possible relevance for (select all that apply)	Would you recommend this item be rated on a dimensional scale?	Comments
☐Drop ☐Maybe ☐Keep	☐None ☐Some ☐Strong	☐10-14 ☐15-17 ☐18-25	☐Females ☐Males ☐Cannot say	☐Noncontact offenses ☐Contact offenses	☐Yes ☐No	

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→ **Importance of sexual abuse** ☐Drop ☐Maybe ☐Keep			**Comments**
1. Age of onset		☐Drop ☐Maybe ☐Keep	
2. Duration		☐Drop ☐Maybe ☐Keep	
3. Person who perpetrated the abuse used:	3a. Violence	☐Drop ☐Maybe ☐Keep	
	3b. Force	☐Drop ☐Maybe ☐Keep	
	3c. Intimidation	☐Drop ☐Maybe ☐Keep	
	3d. Threats	☐Drop ☐Maybe ☐Keep	
	3e. Humiliating/degrading /demeaning elements	☐Drop ☐Maybe ☐Keep	
	3f. Multiple abusers	☐Drop ☐Maybe ☐Keep	
4. Relationship to perpetrator		☐Drop ☐Maybe ☐Keep	
5. Contact or noncontact abuse		☐Drop ☐Maybe ☐Keep	
6. If contact abuse occurred:	6a. Contact, but no penetration or oral sex	☐Drop ☐Maybe ☐Keep	
	6b. Penetration of any kind (e.g., finger, foreign object, mouth, penis)	☐Drop ☐Maybe ☐Keep	
7. If youth disclosed abuse to a person, that person's reaction		☐Drop ☐Maybe ☐Keep	

Figure 3. Example #2 of the survey created for the Advisory Board.

Feedback from all 11 raters was analyzed using SPSS. There was not 100% agreement among all 11 raters to 'keep' any single item, requiring the use of cut offs for percent of agreement: (a) >8 (73% of 11) agreed to 'keep' the item (Criterion #1), or (b) all 11 rated the item 'keep' or 'maybe' and no one rated 'drop' (Criterion #2). See Table 4 for examples of the items that met each Criterion. This procedure reduced the number of dynamic items by 50% (from 54 to 27) and the number of historical items by one third (from 27 to 18) and served as the foundation for the test version of the scale.

In addition to feedback on the factors to include on the test version of the scale, the Advisory Board members suggested utilizing a standardized 4-point rating scale for *all* items. At the outset, we had specific numerical anchors for every item, such as:

- (+2) Regularly involved with prosocial peers (peers with prosocial attitudes, beliefs, and behaviors)
- (-2) Regularly involved with antisocial peers (peers with antisocial attitudes, beliefs, and behaviors)

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OR

- (+2) Successfully manages sexual arousal/urges appropriately
- (-2) Significant problems managing sexual arousal/urges

Our Advisory Board suggested standardizing the ratings such as:

- 0 = No concern
- 1 = Minimal concern
- 2 = Moderate concern
- 3 = Strong concern

Table 4. Potential Test Items

Advisory Board & Core Team Feedback on Potential Test Items		
ITEMS THAT MET CRITERION #1: Items that above 70% of participants wanted to "keep" (*n* = 6 items)	**ITEMS THAT MET CRITERION #2: Items that 0% of participants wanted to "drop" (*n* = 11 items)**	**MET BOTH CRITERIA #1 AND #2 (*n* = 4 items)**
12. Peer involvement associations	5. Sexual regulation	1. Attitudes & beliefs regarding problematic sexual behavior
14. Attitudes & beliefs regarding criminal behavior (nonsexual)	7. Concern about consequences of further problematic sexual behavior	2. Sexual interests
17. Behavioral self-regulation 18. Behavioral impulsivity	9. Sexual outlets 16. Emotional self-regulation	4. Sexual thoughts and urges
41. Quality of peer relationships	24. Coping with stress and adverse life events	15. Rule adherence
48. Caregiver involvement/support in interventions	28. Social skills/social competence Problem-solving skills and strategies 45. Engagement in or commitment to structured, prosocial, organized activities	
	49. Caregiver management/supervision skills	
	50. Caregiver/family social orientation	
	52. Current or discharge community environment	

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Test Version of YNPS Rating Scale

In addition to receiving Advisory Board feedback on the test version of the scale, we received further feedback when met with our sites in person to provide the initial training on the scale. This feedback increased reliability as well as efficiency of implementation. Recommendations included terminology for item definitions that would be better understood by users, as well as language that described degrees of 'need' rather words such as "concern."

After integration feedback from the sites, the finalized test version of the scale incorporated a 4-point rating scale (0, 1, 2, 3) in which all 4 points had discrete, independent meaning and followed a gradient of 'need.' By utilizing a 4-point rating scale, each point of which is independent, eliminated the gray area and monitor changes in risk to reoffend, in a reliable way. The 4-point ordinal scale provided a measure that is designed to capture risk to reoffend as it potentially changes (increases or decreases) over time through the tracking of 'intervention needs.' This paradigm shift away from an exclusive focus on risk to a primary focus on *intervention needs* allows juvenile justice agencies to better allocate resources ('needs') in order to mitigate risk to reoffend, rather than expending valuable resources managing past behavior (static risk factors) without affecting factors related to the offending behavior. This approach, if successful, can substantially reduce the financial burden of housing incarcerated youth and redirect resources to targeted interventions that can hopefully lead to healthier long term outcomes. This paradigm shift is essentially the well-known triage procedure.

The degree of 'need' is captured using the following ordinal rating scale:

- 0 = No need
- 1 = Minimal need
- 2 = Moderate need
- 3 = Strong need

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This approach adheres to RNR's Risk Principle (i.e., allocating resources to those who will benefit most from intervention) and is consistent with RNR's Need Principle (identifying risk relevant intervention targets) and the Responsivity Principle (identifying factors that may influence an individual's ability to benefit from the intervention).

The Final Test Version

The final *test* version of the scale included: 27 items designed to assess dynamic risk and protective factors and intervention response needs that covered multiple domains:

(1) attitudes and beliefs (e.g., criminogenic or positive social attitudes and beliefs),

(2) interpersonal relations (e.g., interpersonal and social skills strengths and deficits, involvement with criminogenic and/or positive peers or social isolation),

(3) behavior (e.g., excessive risk-taking, impulsivity, delinquency, substance use, effective behavior regulation, school stability, work stability), emotional regulation (e.g., anger management),

(4) familial / situational (e.g., caregiver support or disengagement),

(5) community (positive or negative supports or influences), and

(6) psychological functioning (e.g., problem solving, co-occurring mental health challenges).

See Figure 4 for a full list of all test items.

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Figure 4. List of Youth Needs & Progress Scale items tested in the 12-month pilot period.

Possible Concern	*No Intervention Need*	*Possible/Minimal Intervention Need*	*Moderate Intervention Need*	*Strong Intervention Need*
1. Frequency of Sexual Thoughts	*0*	*1*	*2*	*3*
2. Sexual Interests	*0*	*1*	*2*	*3*
3. Self-Sexual Regulation	*0*	*1*	*2*	*3*
4. Understanding Appropriate Sexual Behavior	*0*	*1*	*2*	*3*
5. Understanding the Consequences of Problematic Sexual Behavior	*0*	*1*	*2*	*3*
6. Sexual Attitudes and Beliefs	*0*	*1*	*2*	*3*
7. Behavioral Self-Regulation	*0*	*1*	*2*	*3*
8. School and/or Work	*0*	*1*	*2*	*3*
9. Free time	*0*	*1*	*2*	*3*
10. Law abiding behavior	*0*	*1*	*2*	*3*
11. Attitude and Beliefs regarding Non-sexual Rule Violating and Illegal Behavior	*0*	*1*	*2*	*3*
12. Peer-Aged Friendships	*0*	*1*	*2*	*3*
13. Peer-Associations	*0*	*1*	*2*	*3*
14. Relationship with Primary Caregiver (Client's Perspective)	*0*	*1*	*2*	*3*
15. Adult Mentors (Client's Perspective)	*0*	*1*	*2*	*3*
16. Social Skills	*0*	*1*	*2*	*3*
17. Problem Solving	*0*	*1*	*2*	*3*
18. Emotion Management	*0*	*1*	*2*	*3*
19. Self-efficacy	*0*	*1*	*2*	*3*
20. Compassion	*0*	*1*	*2*	*3*
21. Coping with Sexual Abuse	*0*	*1*	*2*	*3*
22. Coping with Non-sexual Negative Life Experiences	*0*	*1*	*2*	*3*
23. Attitudes Toward Interventions	*0*	*1*	*2*	*3*
24. Management of Co-occurring Psychological and Behavioral Health Challenges	*0*	*1*	*2*	*3*
25. Supportive Caregiver or Significant Other	*0*	*1*	*2*	*3*
26. Stability in Living Situation	*0*	*1*	*2*	*3*
27. Community Support	*0*	*1*	*2*	*3*

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Because the intent of the scale was to capture change, for **Step 6**, the YNPS items and instructions on how to rate each item were programmed into Research Electronic Data Capture software (REDCap), a browser-based, secure web application developed at Vanderbilt University granted for temporary research use to institutional partners. See Figure 5 and 6 for examples of how the test version of the scale was programmed into REDCap for the 12-month pilot period.

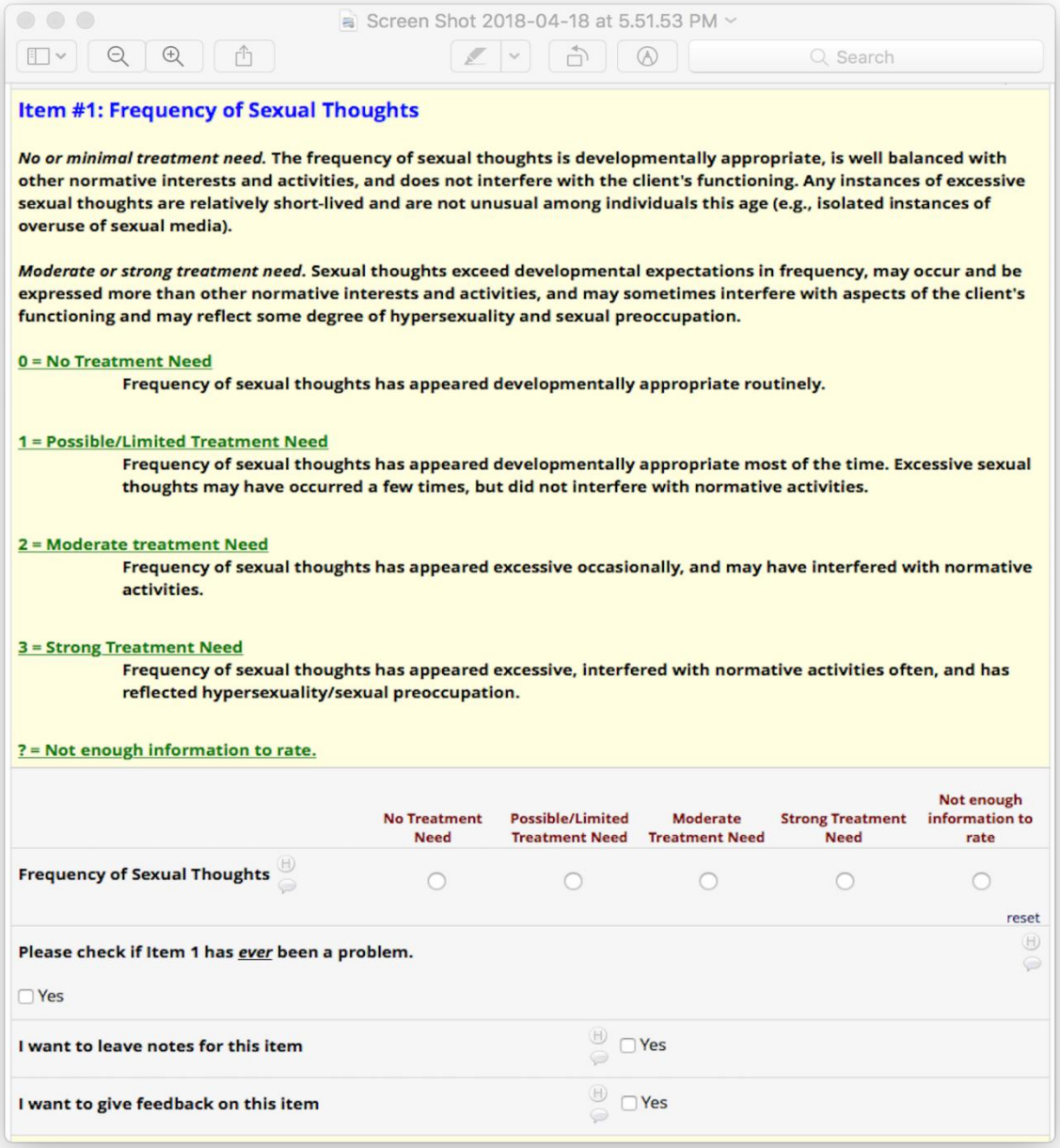

Figure 5. Example #1 of the test version programmed into REDCap.

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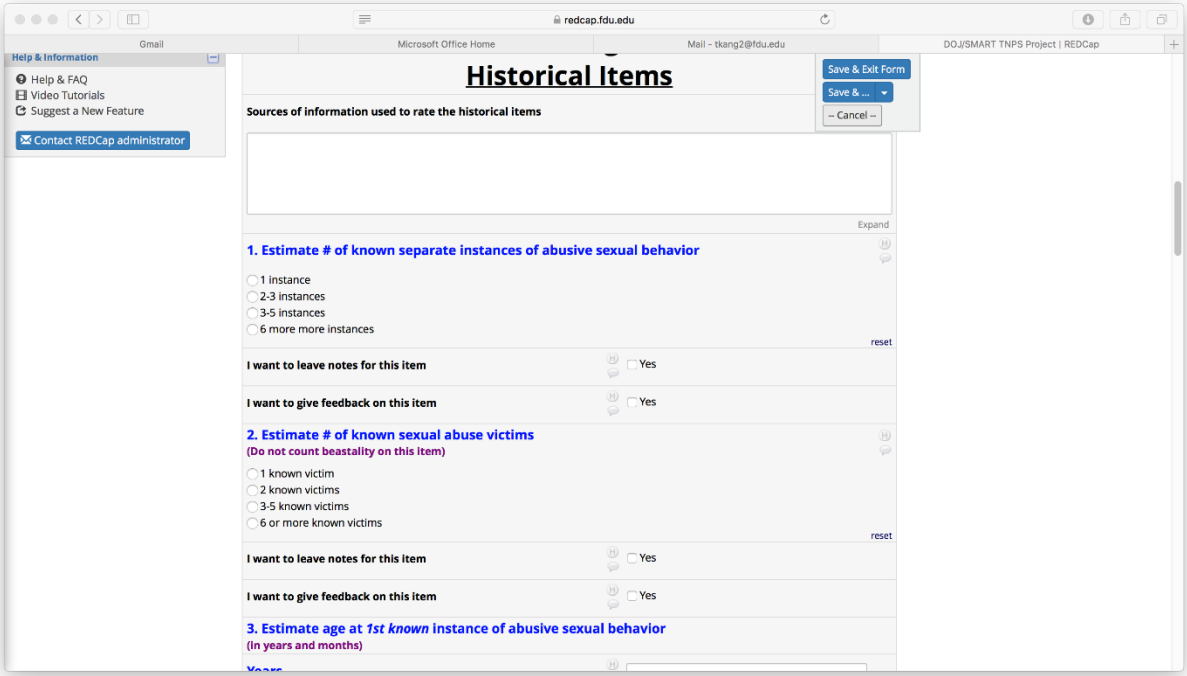
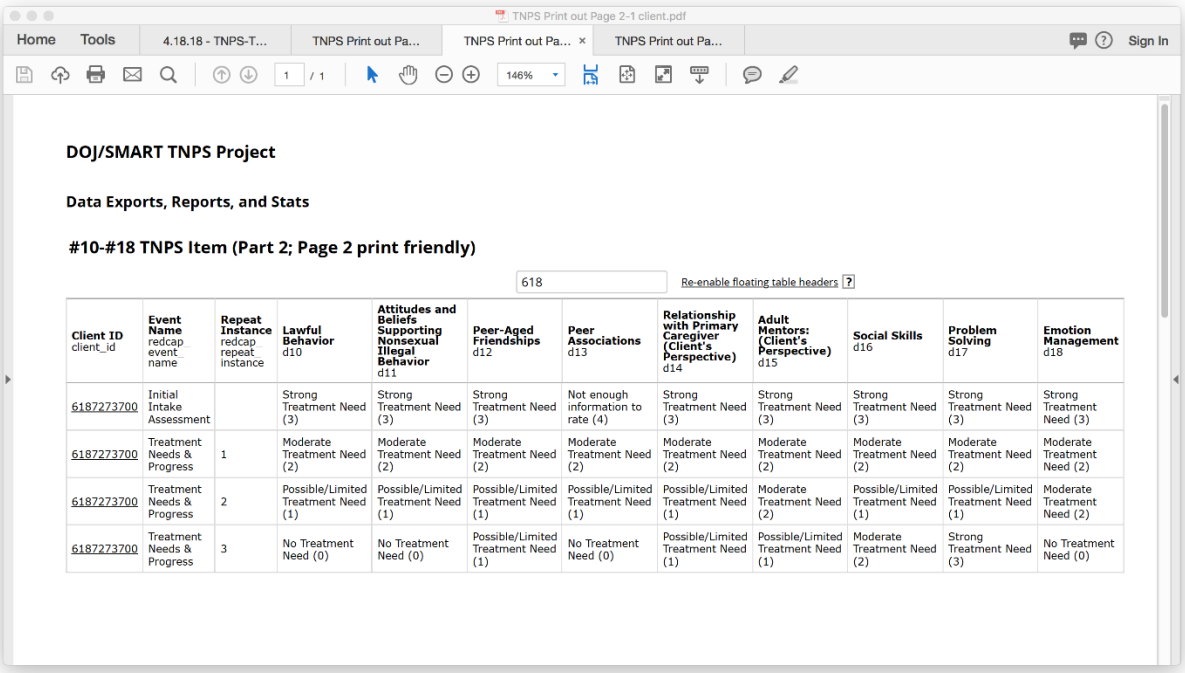


Figure 6. Example #2 of the test version programmed into REDCap.

Among many other features, REDCap provides a table that clearly displays each factor across the top of the page and prior results from each reassessment in consecutive rows to help users visually gauge progress (or lack thereof) and tailor interventions accordingly. See Figure 7 for an example of how REDCap visually captures change overtime. REDCap was not a sustainable option as it can only be used for data capture in research projects. Thus, after the pilot period, we explored proprietary software development options. The purpose of exploring development of software options was primarily to facilitate sustainability, and provide a visual aid to assist stakeholders in monitoring each youth's progress (or lack thereof) while under juvenile justice custody. After exhaustive research, contacting multiple software development companies, having numerous discussions with both software engineers and our participating sites, and obtaining three detailed quotes from different software companies, it was clear that developing proprietary software was not a viable option as long term follow-up assistance and debugging was unavailable. Importantly, after initial software is developed and the grant concludes,

software companies are unable to provide users residual support. Thus, a simple alternative was programming the scale in Microsoft Excel. Excel was used to automate the scoring of the scale and the visual depiction of progress over time. The screenshot below is of REDCap. Appendix B provides screenshot illustrations of the Microsoft Excel application.



Client ID client_id	Event Name redcap_event_name	Repeat Instance redcap_repeat_instance	Lawful Behavior d10	Attitudes and Beliefs Supporting Nonsexual Illegal Behavior d11	Peer-Aged Friendships d12	Peer Associations d13	Relationship with Primary Caregiver (Client's Perspective) d14	Adult Mentors: (Client's Perspective) d15	Social Skills d16	Problem Solving d17	Emotion Management d18
6187273700	Initial Intake Assessment		Strong Treatment Need (3)	Strong Treatment Need (3)	Strong Treatment Need (3)	Not enough information to rate (4)	Strong Treatment Need (3)	Strong Treatment Need (3)	Strong Treatment Need (3)	Strong Treatment Need (3)	Strong Treatment Need (3)
6187273700	Treatment Needs & Progress	1	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)	Moderate Treatment Need (2)
6187273700	Treatment Needs & Progress	2	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Moderate Treatment Need (2)	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Moderate Treatment Need (2)
6187273700	Treatment Needs & Progress	3	No Treatment Need (0)	No Treatment Need (0)	Possible/Limited Treatment Need (1)	No Treatment Need (0)	Possible/Limited Treatment Need (1)	Possible/Limited Treatment Need (1)	Moderate Treatment Need (2)	Strong Treatment Need (3)	No Treatment Need (0)

Figure 7. Example of how REDCap visually depicts progress over time.

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Goal 2: Implementation

Goal #2: Integrate the test version of the scale from Goal #1 into cognitive behavioral intervention programs and facilitate the staff implementation of the scale for initial assessment, intervention planning, and evaluating readiness for discharge

In order to successfully integrate the test version of the scale (YNPS) into each site's cognitive behavioral sex-offense specific intervention program, prior to implementation, information regarding our sites' intervention programs and intervention providers were gathered. There was much diversity in assessment procedures and intervention program components among our participating sites. Please see Table 5 for a brief breakdown of the characteristics of each site's intervention program and assessment procedure.

Table 5. Description of intervention programs among 5 participating sites.					
	SITE 1	**SITE 2**	**SITE**	**SITE**	**SITE 5**
Type of intervention program(s)—if specialized	-High risk to reoffend -Youth transition to community program	-GED, College, Technical focused -Aggression / high-risk -Mental Health -Developmental Disability -Younger youth	-Low, moderate, & high-risk -Girls facility -Group home -Independent living	-High-risk	-Younger youth -High-risk -Girls facility -Mental health
Clinician qualification	MA	BA, MA	BA, MA, Ph.D.	LCSW, LPCA, BSW, MA	BA, MA
Intervention modalities	Individual, group	Individual, group, family	Individual, group, family	Individual, family, group, and nontraditional (e.g., art, equine)	Family, individual, group
Therapeutic interventions	-Cognitive behavior therapy, ”Pathways” workbook	Psychoeducation, Cognitive behavior therapy	Psychoeducation, cognitive behavior therapy	Cognitive behavior therapy, Neuro-sequential model of multisystemic intervention, trauma, Pathways Workbook	Psychoeducation, Cognitive behavior therapy, Dialectical Behavior Therapy
Adjunct intervention	Aggression Replacement Training, trauma, substance abuse, social skill development	Trauma, substance abuse	Trauma, substance abuse	Model of therapeutics, collaborative problem solving, Aggression Replacement Training	Aggression Replacement Training, trauma
Reassessment schedule	Annual or as requested basis	Quarterly	60 days	At a minimum, every 6 months	Quarterly
Security level	Correctional residential	Correctional residential	-Correctional residential -Day intervention -Outpatient	Foster care Day intervention Non-correctional residential Outpatient	Correctional residential

On-Site Trainings

Training materials (e.g., PPT, handouts, post-training surveys) were developed and used for the 3-day on-site initial trainings (Spring, 2018). Project involved intervention providers from 5 states were trained on administration and interpretation of the test version of the YNPS. The training objectives for each day of training are included below:

Day 1 Training Objectives:

- Review important characteristics of youth who commit sexual offenses
    - Adolescent development and maturation
    - Normative and problematic sexual behavior
    - Relevant risk and protective factors
- Discuss evidence-informed effective interventions
    - Assessment approaches
    - Considering and integrating the normative, pervasive developmental flux that defines this transitional period of juvenile's lives.
    - Interventions: What works?

Day 2 Training Objectives: (An incentive training day developed in accordance with the pilot sites expressed interest.

- Identify challenges in conducting risk and needs assessments and some corrective strategies.
- Score and interpret the J-SOAP-II reliably.
- Use the J-SOAP-II to guide decision-making and responsible, effective case and intervention plans.

Day 3 Training Objectives:

- Learn to use the YNPS-TV to facilitate focused and effective intervention planning, progress assessments, and evaluate readiness for discharge
- Score and interpret the YNPS-TV reliably and use it effectively
- Troubleshoot potential implementation barriers and prepare to use the YNPS-TV

101 hours of training were provided to 268 providers, and 100% of the providers reported an increase in knowledge, skills, and/or abilities. During the on-site trainings, the core team received feedback on the YNPS-TV from those intervention providers who would be filling out the scale and assessing the juveniles (see Table 6 for examples of some feedback from our sites).

Table 6. Examples of Feedback from Sites

- Define subjective words such as 'periodically,' 'frequent,' 'several,' 'many,' 'minor,' 'often,' etc.
- Consistent qualifiers across all items.
- Items should capture frequency, severity, and urgency, as all factors affect intervention planning.
- For socio-ecological test items:
    - *What if parent is supportive in general, but not supportive of the youth's participation in the interventions?*

Sustainability and Implementation Challenges

During the training, we also explored potential sustainability and implementation challenges, managing workloads, staff departures, and training new staff at each of our sites (see Table 7 for an overview of predicted implementation challenges). These challenges were, for the most part, site-specific and time-limited. Thus, after the on-site trainings, we incorporated some of our site's feedback.[1] The 12-month pilot period began in April, 2018 and ended in April, 2019.

To ensure fidelity of use, we conducted monthly consultations with pilot site intervention providers who rated the scale. Consultations focused on how to use the YNPS item ratings to inform intervention planning and decision-making and troubleshoot rating issues. Raters and site directors were provided one-on one assistance as requested, participated in refresher webinars, and had the opportunity to provide feedback during consultations and provide feedback anonymously through REDCap. To further increase uniformity of administration at the sites, we

[1] Due to time constraints, we were unable to incorporate *all* of our sites' feedback into the test version for the pilot period, but all feedback was integrated into the final scale revisions.

developed an FAQ sheet to address additional questions during monthly consultations, however, consistent and inter-rater rating difficulties were apparent.

Table 7. Potential Implementation Challenges
(i.e., summary of the qualitative feedback received from our sites)

1. Overburdening staff

1. Many staff are already conducting multiple assessment tools and have a difficult time collecting information on the youth from multiple sources (especially during the intake process).

2. Time it takes to assign to a program

2. Sometimes the youth can be detained for months before getting placed so the assessments, psychosexual evaluations, IQ testing, information from schools, etc. could be over 6 months old when they finally get placed into a program, or may not have been done at all.

3. Different services are offered at different programs

3. Facilities even within one state differ in terms of resources and services offered.

Goal 3: Data Analyses

<u>Goal #3</u>: Examine the relationship between individual YNPS, combinations of said items, and incremental addition of said items to a revised Juvenile Sex Offense Specific Intervention Needs and Progress Scale

To accomplish Goal #3, we retrieved two sources of data for statistical analyses:

1) The REDCap YNPS assessment/reassessment data

2) Site's Routinely Collected Data (RCD)

The REDCap data includes historical information and the YNPS data. Routinely collected data is defined as 'data the site already routinely collects for their management information system.' The routinely collected data (RCD) we requested included the youth's demographics, incident reports, criminal history, J-SOAP and/or ERASOR subscale scores, and recidivism data for youth who were released into the community during the 12-month pilot period.

The original request for data included the following variables:

Requested data included:

- Incident report data
- Demographics (gender, ethnicity, race)
- Criminal history
- Risk measures related to sexual adjustment/regulation (e.g., ERASOR & J-SOAP)
- Risk measures related to nonsexual risk
- Post intervention data (recidivism data)

Missing Data

We faced many challenges in successfully acquiring our sites' RCD (e.g., turnovers of staff in higher administration delayed requests). We were able to successfully collect RCD from four of the five sites. Unfortunately, of the four sites that provided us with the requested RCD,

there was high variability in the number of missing cases, contributing to missing data on gender and ethnicity for 211 (34.9%) of the sample (*n* = 211). Fortunately, the rest of these data (other than gender and ethnicity) were collected via REDCap, so both historical items and dynamic YNPS data were successfully collected and reported below.

Once these RCD were de-identified and securely transferred to the project team (in accordance with IRB requirements), we discovered that our sites did not collect the same type of data and/or had differing definitions and coding for the information entered into their management information system. The differences between sites posed unsurmountable challenges for aggregating data across sites. Further, each variable collected posed operational obstacles that precluded any standardization. Examples of such obstacles associated with each type of data requested are discussed below:

Requested data included:

- **"Incident" report data** (disciplinary reports, observation of behavior reports, etc.)
  - Sites coded different behaviors as "incidents"
  - Even when the behaviors appeared to be the same, they were not coded the same way
  - For some sites, incidents reflected the initial report that triggered further investigation. Once investigated, the youth may or may not have been found guilty of the incident.
  - Incidents such as youth on youth assault, gang violence, youth on staff physical assault, etc. did not indicate *who* instigated the incident.
  - No two sites collected / tracked the same "types" of incidents in the same way.
  - Some of our sites reported multiple incidents for the same day, but it was unclear as to whether these incidents were part of the *same event* or occurred throughout the day.

- **Demographics** (gender and ethnicity)
  - We used REDCap to collect the majority of these data, but in order to ensure no identifying information was collected using REDCap, we did not collect gender or ethnicity. Thus, we had to request these data as part of our RCD request. As discussed above, we were only able to collect RCD from four of the five sites, and thus, we are missing data from 211 (34.9%) of juveniles.

- **Criminal history**
  - Sites only collected qualitative data, not "official" quantitative documentation of criminal offenses.
  - Sites used different language for what appeared to be similar or the same problematic, criminal behavior and "defined" these "offenses" differently.
  - At times, dates for when the offense occurred were not tracked or entered in the site's management information system.

- **Risk measures related to sexual behavior** (e.g., ERASOR & J-SOAP)
  - We were able to collect these data, but some of our sites used the J-SOAP, but did not use the ERASOR and some sites only used the ERASOR and not the J-SOAP.

- **Risk measures related to nonsexual risk**
  - Our sites each had their own unique (non-standardized) in-house nonsexual risk assessment scales that were not similar to other sites' nonsexual risk assessment procedure.

- **Post intervention data** (recidivism data)
  - By the end of the 12-month pilot period, relatively few youths had been released into the community.
  - Some youth could have been rearrested and charged in the adult system, and our juvenile justice agencies do *not have access to this information.*
  - Some sites had different jurisdictions where they tracked their cases. Therefore, if the youth was rearrested in a different jurisdiction, the sites did not have these data.

(See Appendix D: Codebook for the data set that outlines all variables collected). We retrieved RCD from 4 of our 5 sites. One of our sites had *major* turnovers in staff, and paperwork was significantly delayed.

Participants

Demographics. Initial (base-rate) data were collected from 608 youth (well above the 300-500 estimated in our proposal), with an average age of 16 years (M = 16.38; SD = 2.03). The youngest youth was 10 years old and the oldest was 24 years old. Two-thirds of the sample (65.1%) was between the ages of 14-17 (n = 396), slightly under one-quarter of the sample (23.4%) was 18 or older (n = 142) at the time of the initial assessment, and 28 youth were under the age of 14, and there were missing data for 42 cases. Consistent with past research, there were

not many female JSOs in our sample (*n* = 5). We were missing gender data on 35.5% (*n* = 216) of the sample (see explanation above) and 64.1% (*n* = 390) of the 608 juveniles in the sample were male. Although the sample was overwhelmingly Caucasian and African American, these demographics are based on two-thirds of the sample (i.e., we were unable to retrieve ethnicity or race for 35.5% of the sample, see Table 8).

Table 8. Race/Ethnicity	Frequency
American Indian/Alaskan	1
Asian/Pacific Islander	3
African American	99
Biracial	12
Caucasian	248
Hispanic	24
Unknown/Other	5
Missing	216
Total	608

Level of Security. Most of the sample were in a secure facility at the time of the initial assessment (70.9%; *n* = 431), and the majority (76.9%; *n* = 465) were in a state-run facility, with only 17% of JSOs receiving intervention through a private facility. When considering all assessments completed, 1,108 (69.2%) of assessments were completed in a secure facility and 27.7% (*n* = 444) were completed when the juvenile was supervised in the community. It should be noted that "number of assessments" is intake (or baseline) assessment for each youth ***plus*** all re-assessments for that youth.

Intervention Status. Approximately half of the sample were already in intervention prior to participating in this project (58.1%; *n* = 353). Almost all of the sample were compliant with intervention (98.6%) and only 1% refused intervention at the time of the initial assessment.

Sex Offense Related. Approximately half of the sample had only one known victim (50.2%; *n* = 305); 21.8% reported or there was documentation that provided evidence of 2 known victims, 21.7% had evidence suggesting 3 or more known victims, and there were missing data for 6.9% of the sample (*n* = 42). About half of the youth did *not* have evidence of a history of non-contact offending (*n* = 335; 55.1%), 19.7% had 1-2 instances of non-contact offending, only 10.9% of the youth had evidence to support a history of three or more non-contact offenses (*n* = 66; 10.9%), and there were missing data for 14.3% of cases (*n* = 87).

Two-thirds of the sample (67.6%) had a charged sex offense. One-third of the sample (31.7%) did not have a formally charged sex offense (e.g., parent brought the child in for community intervention) or had a charged offense that did not involve sexually abusive behavior but was referred for sex offense-specific treatment, and there were missing data for 4 cases (0.7%). The majority of youth who did not have a charged sex offense had a charged conduct offense (disorderly conduct, probation violation, substance abuse (*n* = 113; 18.6%), a violent offense (*n* = 106; 17.4%; assault, fighting), a property offense (*n* = 82; 13.5%; theft, larceny, robbery, shoplifting), or a status offense (*n* = 76; 12.5%; runaway, truancy, curfew violations, underage drinking).

Conduct Disorder and Delinquency Related. About half of the sample (*n* = 290; 47.7%) had no indications (evidence) of conduct problems prior to the age of 10, 41.9% (*n* = 255) had evidence of major or severe conduct problems prior to the age of 10, and there were missing data for 63 cases (10.4%). A little less than half of the sample had no evidence of

juvenile delinquent behavior after the age of 14 (45.2%; *n* = 275), 47.2% (*n* = 287) had evidence of major or severe juvenile delinquent behavior after the age of 14, and there were missing data 46 cases (7.6%).

History of Abuse and/or Placement Instability. Although placements are common in this population, there was minimal evidence of a high degree of placement instability. Only 14.4% (*n* = 88) of JSOs had 4 or more placement changes and 20.4% (*n* = 124) had 2 to 3 placement changes. Slightly less than one-quarter (23.4%) had 1 placement change, 32.7% (*n* = 199) had no known placement changes, and there was insufficient information for 22 cases (3.6%). In other words, roughly 55% of these youth had either no placement changes or only 1 such change (*n* = 341; 56.1%). Half the youth in this sample (50.7%; *n* = 308) reported no history of sexual abuse. Roughly a quarter of the sample (27.3%; *n* = 166) reported or had documentation that suggested evidence of a sexual abuse history, and there were missing data for 22% of cases (*n* = 134).

Descriptive Statistics on Repeated Assessments. At the end of the 12-month pilot period, intervention providers at the participating agencies had conducted 604 initial assessments of the YNPS, 422 conducted one follow-up YNPS reassessment after 90-days, 239 conducted two follow-up YNPS reassessments, 152 conducted three follow-up YNPS reassessments, 91 conducted four follow-up YNPS reassessments, and 54 conducted five follow-up YNPS reassessments. Although most sites re-assess every 90 days, some sites re-assess after 60 days. The 340 youth with three or more re-assessments provided an opportunity for repeated measures analysis and figural depiction (cf. Trend Analysis). See Table 9 for a summary of the number of assessments at various time points. Overall, 1609 assessments (baseline + reassessments) were completed. Approximately one third of the assessments were initial assessments (34.9%; *n* =

559), approximately half were reassessments (48.4%; *n* = 781), 14.6% were discharge assessments[2] (*n* = 234), and there were missing data for 52 cases (3.2%).

Table 9. Number of reassessments

Assessments	Frequency	Percent
Initial intake assessment	608	37.7
1st reassessment	422	26.2
2nd reassessment	239	14.9
3rd reassessment	152	9.5
4th reassessment	91	5.7
5th reassessment	54	3.4
6th reassessment	28	1.7
7th reassessment	13	.8
8th reassessment	2	.1
Total	1609	100

Principal Component Analysis

A series of three Principal Component Analyses (PCA) were conducted with the goal of reducing the initial 27 YNPS items and creating component scales. All three solutions, for comparison sake, are illustrated in Table 13. The final solution, with rotation to Varimax and loading cut-offs > .45 is illustrated in Table 1.

Component 1: 10 items, loading range - .49 -.78; 24.44% variance explained; Scale $\alpha = .92$

Component 2: 6 items, loading range - .76 - .83; 24.29% variance explained; Scale $\alpha = .94$

[2] A discharge assessment could have been a step down in level of care, transfers to another secure facility, or release into the community

Component 3: 5 items, loading range - .54 - .83; 15.10% variance explained; Total Var. Explained: 63.84%; Scale $\alpha = .81$

Table 10. Cronbach Alpha for YNPS Scales

Scale name	Number of items	Alpha	Item deletion alpha	
			Min	Max
scale1	10	0.92	0.91	0.92
scale2	6	0.94	0.92	0.93
scale3	5	0.81	0.73	0.81

Table 11. Item-Scale Correlations for YNPS Scales

Scale name	With items in the scale		With items not in the scale	
	min	max	min	max
scale1	0.71	0.82	0.37	0.70
scale2	0.84	0.90	0.29	0.66
scale3	0.62	0.82	0.31	0.55

Table 12. Between-scale Correlations for YNPS Scales

	scale1	scale2	scale3
scale1	1	0.73	0.55
scale2		1	0.41
scale3			1

Detailed Process of Item Reduction

First, we conducted a Principal Component Analysis (PCA) with Varimax rotation, suppressing loadings below 0.10. As shown in Table 13, the PCA revealed a four component solution. After reviewing the rotated solution factor loadings, it was clear that this was not a clear, nor practically useful solution. The only component that both the factor loadings and theoretical support aligned was for the sexual items d1 to d6. Thus, after much discussion, we decided to apply the Risk-Need-Responsivity (RNR) framework. Per the RNR framework, four of the 27 items represented 'specific responsivity needs' targeting individualistic needs. Because a PCA is designed to find commonalities rather than identify individualized needs, we decided to remove all specific responsivity needs from the PCA. Items d21, d22, d23, and d24 describe such responsivity needs, such as: (a) having difficulties due to traumatic events, (b) attitudes toward interventions, and (c) mental health management. Following RNR, these constructs are not likely to be related to recidivism reduction. Rather, these individual needs may be associated with difficulties that benefit from some modification that will improve response to interventions designed to reduce reoffending. For our next PCA, d21, d22, d23, and d24, the four items referring to mental health, trauma, and attitudes toward interventions, were removed.

The second PCA included 23 items, and as before, used Varimax rotation and suppressed factor loadings below 0.10. As shown in 'Analysis II' in Table 13, a similar 4 component solution emerged. Component 1 had high loadings on six items (> 0.75) referring to sexual behavior (loadings ranged from 0.76-0.82). Component 2 included 8 items that described general behavior (e.g., school & work commitment, behavior management; loadings ranged from 0.52-0.75), and Component 3 captured socioecological influences, such as family relationships and stability in the individual's living situation (loadings ranged from 0.54-0.82). Component 4 was

less clear as it included more general behavior criminogenic needs and appeared to have needs that overlapped with Component 2. Two items, d10 (*lawful behavior*) and d17 (*problem-solving*) were dropped from the third PCA. *Lawful Behavior* is not dynamic and was conflated with two other "management" items (sexual behavior management and nonsexual behavior management). *Problem-Solving* proved too difficult to assess and rate reliably.

The third (and final) PCA included 21 items again used a Varimax rotation and suppressed factor loadings below 0.10. The PCA found a 3 component solution. Component 1 included needs related to general behavior (most align with RNR's Need Principle, with a few other items related to general behavior, such as social skills and self-confidence). As before, Component 2 included sexual items. Last, similar to the last PCA, Component 3 included socioecological intervention needs. One item, general compassion loaded comparably on both Component 1 and Component 2 (0.02 loading difference). Theoretically, the compassion item captured intervention needs related to *general* compassion and was not specific to sexual intervention needs. Thus, d20, *Compassion*, was included in Component 1. See Table 13 for a comparison of the three PCAs. Red font indicates that the item was dropped and factor loadings higher than 0.50 are highlighted. See Table 14 for the final PCA solution and communalities.

Table 13. PCA I, II, and III	**Analysis I**					**Analysis II**					**Analysis III**		
YNPS Items	**1**	**2**	**3**	**4**		**1**	**2**	**3**	**4**		**1**	**2**	**3**
d1. Sexual Thoughts—Frequency	0.22	0.81	0.16	0.17	d1	0.79	0.21	0.14	0.22	d1	0.27	0.81	0.14
d2. Sexual Interests—Age & Consent	0.23	0.80	0.22	0.11	d2	0.80	0.23	0.19	0.15	d2	0.24	0.80	0.19
d3. Sexual Behavior Management	0.29	0.82	0.14	0.20	d3	0.82	0.24	0.14	0.24	d3	0.30	0.83	0.14
d4. Understands Appropriate Sexual Behavior	0.33	0.81	0.16	0.14	d4	0.81	0.32	0.16	0.12	d4	0.31	0.81	0.16
d5. Understand Consequences- Sexual Abuse	0.23	0.79	0.10	0.21	d5	0.76	0.29	0.11	0.13	d5	0.29	0.76	0.12
d6. Sexual Attitudes and Beliefs	0.26	0.81	0.12	0.25	d6	0.81	0.23	0.14	0.27	d6	0.30	0.83	0.15
d7. Nonsexual Behavioral Management	0.54	0.29	0.17	0.51	d7	0.32	0.52	0.18	0.50	d7	0.68	0.36	0.19
d8. School & Work Commitment	0.68		0.18	0.40	d8	0.10	0.68	0.17	0.37	d8	0.78	0.13	0.17
d9. Use of Unstructured Time	0.59	0.27	0.11	0.39	d9	0.28	0.57	0.19	0.43	d9	0.70	0.31	0.20
d10. Lawful Behavior	0.22	0.30	0.19	0.76	d10	0.36	0.20	0.17	0.80	d10			
d11. Nonsexual Attitudes and Beliefs	0.27	0.30	0.22	0.77	d11	0.32	0.26	0.21	0.78	d11	0.57	0.39	0.22
d12. Peer-Aged Friendships	0.72	0.25		0.13	d12	0.25	0.71	0.13		d12	0.67	0.24	0.13
d13. Peer Associations	0.61	0.19	0.23	0.51	d13	0.22	0.59	0.27	0.50	d13	0.74	0.26	0.27
d14. Client View of Caregiver Relationship	0.23	0.15	0.76		d14	0.16	0.20	0.78		d14	0.21	0.16	0.78
d15. Adult Mentors: (Clients Perspective)	0.30	0.10	0.69	0.13	d15	0.10	0.27	0.62	0.11	d15	0.29	0.11	0.61
d16. Social Skills	0.69	0.43	0.23		d16	0.39	0.73	0.22		d16	0.61	0.38	0.23
d17. Problem Solving	0.75	0.35	0.22	0.19	d17	0.36	0.75	0.24	0.16	d17			
d18. Emotion Management	0.67	0.21	0.27	0.33	d18	0.22	0.63	0.27	0.32	d18	0.71	0.25	0.27
d19. Self-Efficacy	0.69	0.30	0.27	0.19	d19	0.30	0.69	0.25	0.13	d19	0.67	0.31	0.25
d20. Compassion	0.41	0.54	0.32	0.28	d20	0.49	0.40	0.26	0.33	d20	0.50	0.52	0.27
d21. Difficulties Due to Sexual Abuse	0.59	0.31	0.38	-0.14	d21								
d22. Negative Nonsexual Life Experiences	0.41	0.30	0.57		d22								
d23. Attitudes Toward Interventions	0.29	0.43	0.26	0.43	d23								
d24. Mental Health Management	0.64	0.31	0.28	0.26	d24								
d25. Family Functioning	0.12		0.82	0.13	d25	0.12	0.15	0.82	0.22	d25	0.16	0.12	0.83
d26. Stability in Living Situation		0.14	0.74	0.18	d26	0.16	0.12	0.76	0.12	d26	0.16	0.16	0.76
d27. Community Support	0.12	0.17	0.51	0.18	d27	0.10	0.13	0.54	0.15	d27	0.18	0.12	0.54

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Table 14. Factor Analysis on YNPS Items: Varimax Factor Loading and Communality

YNPS Item	Factor1	Factor2	Factor3	Communality
7. Behavioral Self-Management	0.68	0.36	0.19	0.63
8. School and/or Work	0.78	0.13	0.17	0.65
9. Free Time	0.70	0.31	0.20	0.62
11. Attitudes and Beliefs Supporting Nonsexual Illegal Behavior	0.57	0.39	0.22	0.53
12. Peer-Aged Friendships	0.67	0.24	0.13	0.52
13. Peer Associations	0.74	0.26	0.27	0.69
16. Social Skills	0.61	0.38	0.23	0.57
18. Emotion Management	0.70	0.25	0.27	0.63
19. Self-Efficacy	0.67	0.31	0.25	0.60
20. Compassion	0.49	0.52	0.27	0.59
1. Frequency of Sexual Thoughts	0.26	0.81	0.14	0.74
2. Sexual Interests	0.24	0.80	0.19	0.74
3. Sexual Self-Management	0.30	0.83	0.14	0.80
4. Understanding Appropriate Sexual Behavior	0.30	0.81	0.16	0.78
5. Understanding of the Consequences of Abusive Sexual Behavior	0.29	0.76	0.12	0.68
6. Sexual Attitudes and Beliefs	0.30	0.83	0.14	0.80
14. Relationship with Primary Caregiver (Clients Perspective)	0.21	0.16	0.78	0.67
15. Adult Mentors: (Clients Perspective)	0.29	0.11	0.61	0.47
25. Supportive Primary Caregiver or Significant Other	0.16	0.12	0.83	0.72
26. Stability in Living Situation	0.16	0.16	0.76	0.63
27. Community Support	0.18	0.12	0.54	0.34
				.
% variance Explained	24.44	24.29	15.10	.
Cumulative % variance explained	24.44	48.74	63.84	.

Final, Revised YNPS Item Selection

The final, revised, YNPS included all items from the third PCA. Two of the 21 items were 'peer associations' and 'peer-aged friendships.' Originally, these were piloted as two separate items, because theoretically they are two different intervention needs. *Peer-aged Friendships* was designed to assess whether the juvenile was capable of forming and retaining friendships with peer-aged individuals. In contrast, *Peer Association* was designed to assess whether those peer-aged friendships and casual associations were with individuals who were supportive of antisocial behavior, thoughts, beliefs, and attitudes. We combined the two items into a single item as the distinction was minimal (*Relationships with Peers*) that included both aspects of these intervention needs. Thus, the PCA contributed to 20 items on the revised YNPS.

Originally, specific responsivity intervention needs were included on the scale. Thus, to still capture these important, individualized needs, we added 'Scale 4,' which was not derived from the PCA, but included two specific responsivity items (i.e., mental health management and participation in interventions). The final, revised YNPS included 22 items.

Although the 20 items were derived from the PCA, we considered many sources of information when tailoring the content and language choices used in the revised scale. Thus, the YNPS was revised based on:

- Results of the statistical analyses presented above
- Theoretical support for the items
- Feedback provided by our sites and Advisory Board.

See the section below entitled **The Youth Needs and Progress Scale-Final Version** for further discussion of the final scale revisions. Also see Appendix C for the scale and User Guide.

Trend Analysis

The YNPS was designed to be sensitive to developmental changes over time. We conducted a repeated measures trend analysis of the reassessments using the three subscales that emerged from the PCA. The trend analysis captures the change of level of intervention need (no need, minimal need, moderate need, severe need) over the course of intervention. As Figure 8 and Table 15 shows, the YNPS is able to capture change in intervention needs across four reassessments. These results do not pertain to efficacy of intervention programs, as it is unclear from these data whether the change captured by the YNPS was a function of growth / adolescent development or intervention.

Figure 8. Trend of YNPS subscales over assessment time.

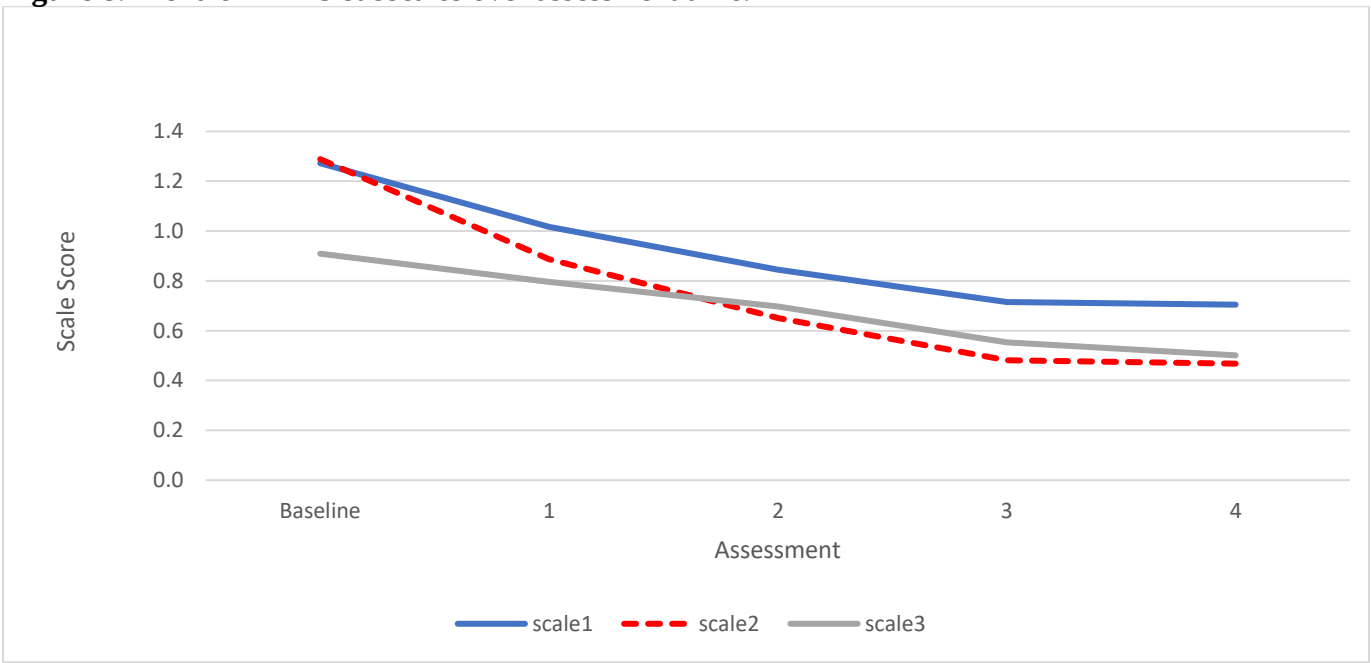

Table 15. Assessments over time.	Baseline	1	2	3	4
scale1	1.272	1.017	0.845	0.715	0.704
scale2	1.288	0.887	0.651	0.481	0.468
scale3	0.909	0.796	0.697	0.553	0.501

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Cluster Analysis

Juvenile who have sexually offended are understood to be a markedly heterogeneous population (e.g., Knight & Prentky, 1993). We conducted a cluster analysis to determine if, within our sample, there are subgroups of youth that are homogenous with respect to their risk-related needs, as well as other distinctive facets, such as prior history of adverse life experiences and subsequent history of offense-related and disciplinary problems. The four-cluster solution explained the most cumulative variance (61%) when compared to the three-cluster and two-cluster solutions.

- **Cluster 1** included juveniles who had many more intervention needs and a more extensive history of problematic sexual behavior. Cluster 1 also appeared to have a more extensive history of delinquent behavior when compared to the other clusters. This group may benefit from intensive interventions.
- **Cluster 2** included juveniles who *did not* have many intervention needs and *did not* have an extensive history of sexual or delinquent behavior. These juveniles may require little to no intervention. Agencies may want to reserve more intensive interventions for different juveniles who may benefit much more.
- **Cluster 3** appears to have many intervention needs, much like Cluster 1, but did not have an extensive history of problematic sexual behavior or delinquency.
- **Cluster 4**, like Cluster 1, had a more extensive history of problematic sexual behavior (and no delinquency) and did not appear to have many intervention needs. A summary of the characteristics of each cluster are in Table 16.

Table 16. Summary of characteristics of each cluster from the 4-cluster solution		
	Commonalities	**Mean**
Cluster 1 (n = 109)	• **↑ on current general behavior, sexual behavior, & socio-ecological intervention needs**	1.89
	• Moderate on history of prior delinquency problems	0.91
	• **↑ # of prior problematic sexual behavior incidents & # of sexual abuse victims**	1.42
Cluster 2 (*n* = 217)	• ↓ on current general behavior, sexual behavior, & socio-ecological intervention needs	0.61
	• ↓ on history of prior delinquency problems	0.45
	• ↓ # of prior problematic sexual behavior incidents & # of sexual abuse victims	0.34
Cluster 3 (*n* = 147)	• **↑ on current general behavior, sexual behavior, & socio-ecological intervention needs**	1.68
	• ↓ on history of prior delinquency problems	0.69
	• ↓ # of prior problematic sexual behavior incidents & # of sexual abuse victims	0.40
Cluster 4 (*n* = 122)	• Moderate current general behavior, sexual behavior, & socio-ecological intervention needs	0.81
	• ↓ on history of prior delinquency problems	0.64
	• **↑ # of prior problematic sexual behavior incidents & # of sexual abuse victims**	1.31

Canonical Analysis with J-SOAP-II

A canonical correlation analysis was conducted to examine how much information is shared between the J-SOAP-II and YNPS. Specifically, the analyses described below examined how much variation in each J-SOAP scale item can be explained by the YNPS total score. J-SOAP-II scales 1, 2, 3 have 23 items total. Scale 4 was not examined as the majority of our youth were incarcerated and J-SOAP-II scale 4 can only be used with juveniles supervised in the community. We derived 21 pairs of canonical variates between the two scales (J-SOAP-II and YNPS). Each canonical variate is a weighted average of scale items. The first pair of variates has the highest correlation between scales, the second pair the second highest, and so forth. Furthermore, canonical variates from the same scale are orthogonal, meaning uncorrelated.

Among 21 pairs of canonical variates, the first 3 variates have a squared canonical correlation of > = 0.33 (Table 17).

Table 17. Canonical correlation analysis

Canonical Analysis Based on 198 Observations Canonical correlation analysis for items from J-SOAP scales 1 and 3 and items from YNPS scales 1 to 3			
Pair number of canonical variates	**Canonical correlation**	**Squared canonical correlation**	***p* value for Test of H_0: The canonical correlations in the current row and all that follow are zero**
1	0.7465	0.5573	< .0001
2	0.6740	0.4543	0.0009
3	0.5786	0.3347	0.11

More specifically, Table 18 shows how much variability the YNPS explains of each J-SOAP-II item. Table 18 organizes the variability explained from most variability to least for each of the three J-SOAP-II scales. Red font indicates that the YNPS explains much variability in that specific item, when compared to the other J-SOAP-II items. Figure 9 shows that, item by item, how much (or how little) of information contained in each item of J-SOAP-II is shared by the YNPS.

The top 5 J-SOAP items which have the **least** in common ($R^2 < 4.0\%$) with the YNPS are J-SOAP-II items:

- Internal motivation for change ($R^2 = 2.1\%$ variance explained), (J-SOAP Scale 3)
- Male child victim ($R^2 = 2.7\%$), (J-SOAP Scale 1)
- Accepting responsibility for offense(s) ($R^2 = 2.8\%$), (J-SOAP Scale 3)
- Understands risk factors ($R^2 = 3.3\%$), (J-SOAP Scale 3)
- Remorse and guilt ($R^2 = 3.7\%$). (J-SOAP Scale 3)

The next items ($R^2 < 7\%$) are:

- Empathy ($R^2 = 4.1\%$), (J-SOAP Scale 3)
- Duration of sex offense history ($R^2 = 5.1\%$), (J-SOAP Scale 1)
- Degree of planning in sexual offense(s) ($R^2 = 5.8\%$), (J-SOAP Scale 1)
- Sexual drive & preoccupation ($R^2 = 6.1\%$) (J-SOAP Scale 1)
- Cognitive distortions ($R^2 = 6.5\%$) (J-SOAP Scale 3)

The top 5 J-SOAP-II items which have the **most in common** ($R^2 = 14.3\%$ to 25.1%) with the YNPS include:

- Multiple offense types ($R^2 = 25.1\%$) (J-SOAP Scale 2)
- Juvenile antisocial behavior ($R^2 = 21.9\%$) (J-SOAP Scale 2)
- Prior legally charged sex offenses ($R^2 = 16.5\%$) (J-SOAP Scale 1)
- Ever charged or arrested before the age 16 ($R^2 = 15.7\%$) (J-SOAP Scale 2)
- Sexualized aggression ($R^2 = 14.3\%$) (J-SOAP Scale 1)

Table 18. % of variability that the YNPS explains in each item of J-SOAP scales 1, 2, and 3.

J-SOAP SCALE 2: Impulsive /antisocial behavior			J-SOAP SCALE 1: Sexual drive/ preoccupation			J-SOAP SCALE 3: Intervention		
Item #	**Item name**	**% of variability explained by INPS**	**Item #**	**Item name**	**% of variability explained by INPS**	**Item #**	**Item name**	**% of variability explained by INPS**
7	Multiple offense types	25.1	1	Prior legally charged sex offenses	16.5	7	Quality of peer relationships	10.0
5	Juvenile antisocial behavior	21.9	6	Sexualized aggression	14.3	6	Cognitive distortions	6.5
6	Ever charged or arrested before age 16	15.7	2	# of sexual abuse victims	12.4	4	Empathy	4.1
4	History of conduct disorder	11.6	8	Sexual victimization history	7.1	5	Remorse & guilt	3.7
8	History of physical assault and/or exposure to family violence	11.5	7	Sexual drive & preoccupation	6.1	3	Understands risk factors	3.3
3	School behavior problems	10.0	5	Degree of planning in sexual offense(s)	5.8	1	Accepting responsibility for offense(s)	2.8
2	Pervasive anger	8.8	4	Duration of sex offense history	5.1	2	Internal motivation for change	2.1
1	Caregiver consistency	3.0	3	Male child victim	2.7			

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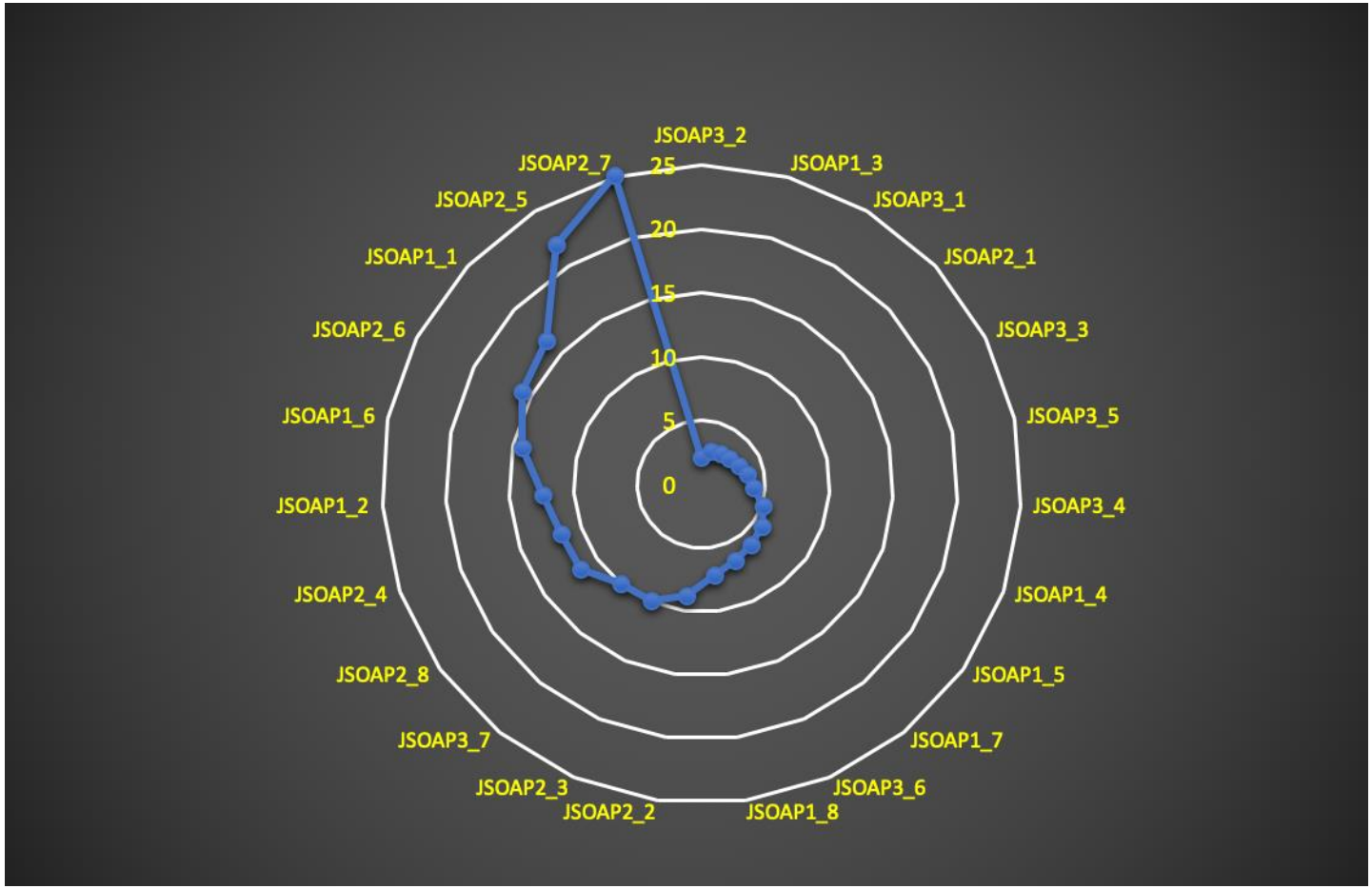

Figure 9. Relationship between each J-SOAP item and the YNPS.
Pictorial diagram of the Max R-squares for items from J-SOAP scales 1 to 3 explained by canonical variates composed of items from YNPS scales 1 to 3.

Significant Findings

The Principal Component Analysis (PCA) revealed 3 distinct areas of intervention that included:

1) General behavior
2) Sexual behavior
3) Socio-ecological supports and stability
4) & Specific Responsivity needs (*not derived from the PCA*)

The 4th subscale was not derived from the PCA but contains intervention relevant factors that may be presenting barriers to the juvenile's ability to respond effectively to the intervention. Each subscale is comprised of dynamic risk-relevant and related intervention needs. The 4 scales presented above are consistent with the well-researched Risk-Need-Responsivity (RNR) model of offender rehabilitation (Bonta & Andrews, 2017). See Table 19 on how the three areas of intervention relate to the RNR Framework

Table 19. YNPS & Risk-Need-Responsivity Framework
Table 19 represents how the YNPS used the Risk-Need-Responsivity Framework as the building blocks for the creation and revision of the YNPS

YNPS Subscales	Risk-Need-Responsivity (RNR) Framework
Scale 1: **General Behavior** • d7. Nonsexual Behavioral Management • d8. School & Work Commitment • d9. Use of Unstructured Time • d11. Nonsexual Attitudes and Beliefs • d12, d13. Peer-Aged Relationships • d16. Social Skills • d18. Emotion Management • d19. Self-Efficacy / Self-Confidence • d20. Compassion	**Need Principle** • Antisocial attitudes and beliefs • Antisocial personality characteristics (e.g., impulsivity) • Antisocial peers / Social supports for crime • School / Work • Leisure activities **Responsivity Principle**: **Specific Responsivity Needs** • Self-efficacy • Social skills
Scale 2: **Sexual Behavior** • d1. Sexual Thoughts—Frequency • d2. Sexual Interests—Age & Consent • d3. Sexual Behavior Management • d4. Understands Appropriate Sexual Behavior • d5. Understands Consequences of Sexual Abuse • d6. Sexual Attitudes and Beliefs	**Need Principle** **(but focused on sexual behavior –rather than "general antisocial behavior")** • Attitudes & beliefs • Impulsivity, behavior management • Cognitive distortions
Scale 3: **Socioecological Supports & Stability** • d14. Client View of Caregiver Relationship • d15. Adult Mentors: (Clients Perspective) • d25. Family Functioning • d26. Living Situation –Safety & Stability • d27. Involvement in Community Resources	**Need Principle** • Family / Martial • Social supports for crime
Scale 4: **Specific Responsivity Needs** (not empirically derived from PCA): • d23. Participation in Interventions • d24. Mental Health Management	**Responsivity Principle**: **Specific Responsivity Needs** • Motivation to participate in interventions • Mental health
References: • Psychology of Criminal Conduct, 6th edition, Bonta & Andrews (2017) • https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx#a4 • Bonta & Andrews (2007)	

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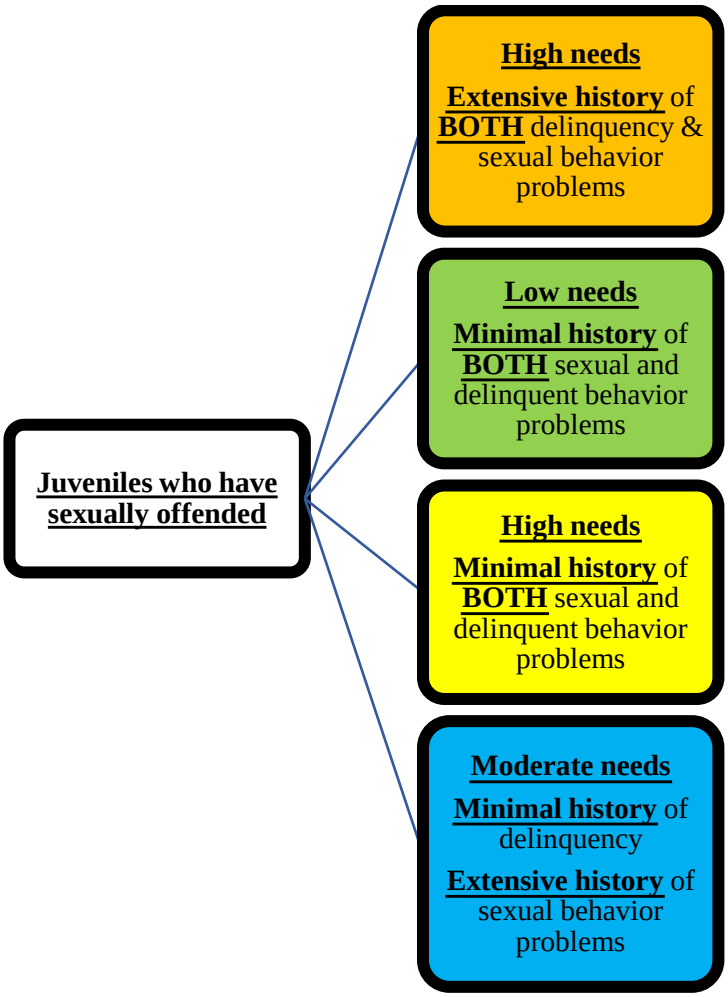
The cluster analysis affirms what has long been known that juveniles who have sexually offended are a markedly heterogeneous population, underscoring that any 'one size fits all' intervention plan will **not** be optimal; optimal interventions **must** be tailored to individual's needs (i.e., individualizing intervention / management plans is critical for reducing reoffending). Further, although it appears that all juveniles who have sexually offended are often considered to be one univocal category of youth, the cluster analysis confirms otherwise, that there are at least (in our samples) four quite unique groups of juveniles who have sexually offended with different intervention needs and different histories. Indeed, there was a group of juveniles that did not appear to need any intensive interventions, potentially benefitting from no more than minimal psychoeducation. Providing intensive intervention for these youth may well be counterproductive and *increase* the likelihood of re-offense. As Lowenkamp & Latessa (2004) found, individuals with a small amount of risk relevant needs may get worse if they are subjected to intensive interventions. Thus, allocating agency resources to individuals with more risk relevant needs with help agencies derive the greatest benefit out of limited resources. This advantage we simply note as triaging.

Lastly, Scales 1–3 of the J-SOAP-II a risk assessment scale, includes both historical and dynamic items and appears to provide unique information from the YNPS, as the YNPS total score explained at most only 25% of the variability in a single J-SOAP item (*Multiple Offense Types*). On the other end of the spectrum, there were some items on the J-SOAP-II that the YNPS total score explained a mere 2% of the variability (*Internal Motivation for Change*). Internal Motivation for Change is an extraordinarily difficult item to rate reliability and will be dropped from Scale 3 in the revision of the J-SOAP-II. These analyses were, and will continue to be, critical in enhancing the efficacy of the dynamic items on the J-SOAP. Further exploration

is needed to identify how much unique information is provided by each of these assessment tools. Although more research is needed, it is clear that the YNPS does not "overlap" with the J-SOAP. The J-SOAP was designed as a risk assessment scale, while the YNPS was designed to optimize interventions for mitigating re-offense: *Tracking progress (or lack thereof) overtime and individualizing interventions will be most successful at reducing reoffending.*

Figure 10. Cluster analysis: Heterogeneous groups
Juveniles who have sexually offended are different although they have committed a seemingly, similar class of offense (i.e., a sex offense).



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Lessons Learns

Feedback reported by project participants was very helpful in discerning both distinct advantages as well as distinct challenges associated with using the scale.

Strengths and positive findings included:

- The scale was generally easy to use.
- It gave focus and direction to treatment.
- The scale was useful for treatment planning and identifying treatment goals, needed interventions, and progress.
- It was useful for team meetings.
- The scale helped the conversation regarding where treatment should go and how to help youth that are struggling.
- Reassessments over time, depicted linearly in graphs provided very helpful visual feedback for treatment planning as well as communicating with clients and stakeholders, including those within the juvenile justice system. Instead of focusing on a youth's past conduct, changes as a function of interventions helped to re-focus on the youth's present emotional, behavioral, and attitudinal state.

Limitations and challenges included:

- Items could be difficult to rate, particularly when available information was limited, such as at intake.
- Obtaining necessary information, especially detailed historical information, could be difficult.
- Fine distinctions were occasionally required. Needed more specific distinctions to differentiate between 0/1, 2/3, and 2/3 in terms of "need".
- The inevitable heuristics that bias rater's "interpretations" (or "meanings") of items, hence the rating of items need clear and specific item definitions.
- Community settings differ from locked facilities; items must be geared for both.
- Need to ensure ongoing inter-rater reliability.
- Need help on using the scale to identity and guide optimal interventions.
- Need a format to view progress quickly and easily (addressed in Excel program);
- Need to integrate the scale into agencies' management information systems. (Excel program provided to project sites).

Other reported difficulties included specific implementation challenges, such as managing workloads, particularly with staff departures and vacancies, as well as training new staff. These challenges, to some extent, were situational and time limited and sites planned to

develop ways to support scale implementation, such as by periodic case consultations and training new staff. Whenever possible, the concerns addressed by the pilot sites were addressed in the revised version of the scale. For example, site staff reported considerable variability regarding the availability and quality of historical information, and we were concerned about the reliability of the collected information.

Final Version of the Youth Needs and Progress Scale

In addition to the empirical findings reported above, the pilot site feedback was instrumental for improving and refining the pilot version of the scale and developing this final version of the scale. Site feedback was obtained in multiple ways, such as at monthly consultations, email communications, and the confidential REDCap ratings used during the pilot phase. Also, a focus group of "team leaders" from each site, and some of their staff, helped summarize their experiences implementing the test version of the scale and its strengths, limitations, and challenges. The Advisory Board read a draft version of this final YNPS and provided detailed feedback as well.

Although it was our goal to develop a scale of predominantly dynamic items that would be responsive to intervention, ignoring history is folly as history itself can be a clear signal for needed interventions (e.g., a history of child abuse). The difficulty of obtaining reliable historical information for intake ratings, however, prompted removal of historical items; the role of historical information was addressed statistically using "routinely collected data" available at some, but not all, sites.

Clearly, rater reliability is indispensable. Formal testing of interrater reliability, however, was not conducted during the pilot for the practical, but unfortunate, reason of staff workload. Feedback from participants indicated that asking them to take the time to double rate additional cases would be unduly burdensome. In some locations, there was only one clinician was on site, and arranging for someone else to rate the same case would have been impossible. Although no adequate substitute for formal examination of reliability, pilot site staff comments and observations during monthly consults indicated that several items were often difficult to rate. This feedback was used to clarify the intent of those items and the descriptive language for rating them.

We began finalizing the scale by conducting a critical review of *all* of the items, the rating procedures, and the apparent overlap between items. Item reduction was described above and four of the dropped items were clearly conflated with other items; the two items regarding peer relationships were combined into one, reducing the number of items from 27 to 22. We edited other items to further reduce redundancy between items and increased item clarity, simplicity and succinctness. Item labels were improved. We enhanced our rating instructions to help users better distinguish the extent to which each rating in the 4-point ordinal scale (0 – 3) indicated *different degrees of intervention need* or whether intervention is needed at all (c.f., Youth Needs and Progress Scale and User Guide).

The final stage again sought Advisory Board input. Their reviews and detailed comments further improved the scale. We also invited volunteers from the sites to provide feedback, and their comments were helpful as well. As a result of these multiple collaborations and revisions, the final scale version has fewer items (22-item) and is easier to rate, a conclusion reported by the volunteer reviewers, Advisory Board members, and site participants during the final on-site training workshops. The final version is accompanied by a User Guide provided in Appendix

C). After scale revisions were completed, training materials were developed on how to use the revised scale (see Appendix A). Dr. Righthand held two-day, on-site post-pilot trainings on the revised scale, as well as training/consultation designed to promote sustainability beyond the end date of the project. All training materials for the revised scale are in Appendix A.

In summary, the YNPS is an empirically-informed, dynamic needs and progress scale. Its development benefited from being piloted for nearly a year at varied sites across the U.S., and detailed feedback and recommendations from the those involved in the pilot project and our Advisory Board members. Project findings suggest that the YNPS can help identify specific intervention needs that can be included in individualized management and case plans, and that reassessments using the YNPS can help assess behavior change, thereby guiding case and intervention planning. Ongoing empirical validation of the YNPS will be an important next step.

Significant Policy Implications

This entire project was focused on one mission: improving the efficiency and the effectiveness of our management strategies for youth who have sexually offended. The overwhelming empirical literature addressing developmental change in youth suggests, at the very least, that errant behavior is not fixed or hard-wired and thus cannot easily be predicted given the flux of developmental change and the inherent unknowability, and thus unpredictability, of adolescent lives. That does not mean of course that such behavior should be ignored. On the contrary, it is our responsibility to respond. The fundamental question is how to respond in a way that maximizes effectiveness and minimizes cost.

Effectiveness was operationalized in this project in terms of capacity to mitigate *all* aspects of risky behavior, not just the referral or index offense/s, as well as improving the quality of interpersonal relationships, especially those relationships that involve intimate partners.

Minimization of cost is an issue that is transparently obvious. *All* future criminal behavior poses a significant cost, not just to its victims but to society at large. The "cost" of such behavior is measured not only in identified future criminal acts but in numerous other burdens placed on society, such as drug and alcohol abuse, depression and other mental health issues, domestic violence and financial irresponsibility. There is no single, uniformly applied algorithm for the problems giving rise to sexual assault. The same patchwork quilt of problems that may lead to sexual assault may also lead to a host of other societal challenges. They must all be addressed if the youngsters we deal with are to live more productive, salutary lives, particularly with respect to their interpersonal relationships. Simply stated, that is what they project was all about – a laser focus on the individual remedial needs of youth that might mitigate risk and restore sufficient self-esteem to pursue productive lives.

We fully recognize that resources, financial and otherwise, are limited. What we are suggesting is consistent with that limitation: optimizing outcomes while minimizing costs. Simply stated, targeting critical risk-related needs and addressing them can help all decision makers, not just clinicians, identify needs more reliably and address those needs more efficiently. What we are advocating is nothing more than triaging by adjusting allocation of resources, a strategy routinely employed in clinical / psychiatric / ER settings as well as the military for earmarking intensiveness of service provision based on degree of urgent need. It is markedly inefficient, if not counterproductive to be allocating resources evenly across markedly uneven needs. We end up over-managing some while under-managing others, leaving both at potentially higher risk (in the former case, excessive intense management of lower risk youth may have the paradoxical effect of increasing risk).

Although the triage task is no less important for youth, it is different; youth are not fully developed adults. Given that all youth, up until roughly the age of 25, are in a period of rapid developmental change, we simply cannot assume stability of any core set of embedded "risk factors" that will increase the likelihood of re-offense years into the future. Hence, it is indefensible to manage youth the same way that we manage adults, where past behavior is often considered prologue to future behavior.

Although the YNPS is designed to help manage juveniles with a sex offense, the YNPS *alone* can never mitigate risk, and its assistance with guidance, intervention, and management can be no better than the fidelity with which it is used (Viljoen et al., 2018). Thus, it is important to note that the YNPS was *not* designed or tested as a risk assessment scale. The intervention needs measured by the scale are not all directly causally related to re-offense risk. They were selected and tested for a different purpose: *guiding and optimizing interventions that promote improved long term psychological health.* Thus, deriving some form of 'risk score' by simply adding up all of the risk-related needs, however, may be quite misleading as it inevitably misses critical, empirically-validated risk-related factors that might only emerge from a comprehensive idiographic evaluation. In the same vain, the YNPS was not intended to replace scales specifically designed and validated to assess re-offense risk in juveniles that have committed sex offenses. The explicit purpose of the YNPS was to identify risk-relevant dynamic factors subject to modification through intervention thereby potentially reducing harmful behavior.

In summary, the YNPS can facilitate communication among stakeholders, both clinicians as well as those within the juvenile justice system, and guide intervention and management planning to assist all stakeholders in rendering more effective and efficient management decisions of juveniles with sex offenses. In summary, the YNPS scale may improve decision

making regarding the management of juveniles with sex offenses, reduce the financial burden of incarceration, inform public policy and law, and ultimately facilitate better outcomes.

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Appendix A: Training Materials

THE INTERVENTION NEEDS AND PROGRESS SCALE

(AKA: INPS) Part 1

Product of DOJ Grant # 2016-AW-BX-K004: Assessing, Treating And Managing Juveniles With Illegal Sexual Behavior: The Juvenile Treatment Progress Scale Development And Implementation Project Awarded To Fairleigh Dickinson University.

Presentation by: Sue Righthand, Ph.D., Fall 2019
sue.righthand @gmail.com

1

TRAINING GOALS

- Explore the need for an empirically-informed intervention needs and progress scale.
- Increase knowledge of the development, testing and implementation of this revised version of the INPS.
- Understand the rationale for each item, what the item assesses; rate INPS item examples reliably.
- Use the INPS to identify appropriate treatment targets, facilitate treatment planning, assess progress, and evaluate readiness for treatment completion.
- Recognize some of the challenges involved in implementing the INPS and discuss possible ways to resolve obstacles.

2

DO WE NEED ANOTHER SCALE?

- There are problems with risk assessment scales.
- Clients change.
- It was time to build on knowledge gained & develop a measure to:
  - *Objectively identify intervention needs &*
  - *Progress toward resolving those needs.*

3

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PROBLEMS WITH RISK ASSESSMENT?

- *"Research concerning the factors that place juveniles at risk for sexual offending behavior and sexual recidivism is still in its infancy* as is research on the capacity of risk assessment instruments to accurately predict risk for sexual recidivism."
  (https://smart.gov/SOMAPI/sec2/ch4_risk.html#riskjuv, also see Worling, http://www.profesor.ca/history--rationale.html)

4

THERE ARE OTHER PROBLEMS

- "Risk assessment" is frequently used interchangeably with risk *prediction*.
- Prediction assumes we will be able to accurately forecast human behavior.
  - ➢ *Human behavior involves an interplay of biopsychosocial individual & socio-ecological factors*.

(c.f., Belsky, 1980; Bronfenbrenner,1977; Cicchetti & Toth, 2009; Lussier, 2015)

5

THERE IS A DEMAND FOR RISK ASSESSMENT & PREDICTIONS

- Willingness to go beyond research evidence,
  - For example, by providing risk labels, levels, and predictions not scientifically grounded.
    (c.f., ATSA, 2017; Lehmann, Thornton, Helmus, and Hanson, 2016)
- Disregarding practice guidelines, e.g.,
  - Not emphasizing the rapidity of adolescent development and the need for frequent reassessment.
  - Not describing the strengths and limitations of assessment methods and findings (c.f., ATSA, 2017).
- ➢ **Not emphasizing risk usually doesn't = reoffending.**

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MOST STOP!

- Sexual recidivism rates are low
  - Generally 3-15% (Caldwell, 2017; Finkelhor, et al., 2009)
- Non-sexual recidivism typically is much greater!
  - ***It is difficult to predict infrequent events!***
  - ***More predictions of risk & violence are wrong than right!***

7

ADDITIONAL PROBLEMS WITH RISK ASSESSMENT

- *Viljoen, Cochrane, & Jonnson, 2018* systematic review of 73 violence risk assessment studies.
- "Despite some promising findings, professionals do not consistently adhere to tools or apply them to guide their risk management efforts" (p. 181).
- When tools are used, those with greater risks may receive more intensive services, but risk management needs are often not addressed.

8

RATHER THAN PREDICTION→

- Assess risk-relevant *needs*:
  - *Identify factors that may increase risk,*
  - *Identify those that may protect & mitigate risk,*
  - *Assess how they interact currently & in the foreseeable future.*

& Recommend / provide interventions that:

- *Address dynamic risk & protective factors to reduce risk,*
- *Develop pathways that promote desistance from antisocial & abusive behaviors.*

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ASSESSMENT IS A PROCESS, NOT AN EVENT

- *Assessments & timely reassessments are important for:*
  - ✓Developing & revising intervention plans,
  - ✓Guiding case management decisions,
  - ✓Evaluating individual progress & outcomes,
  - ✓Program evaluation.
- *Yet, there are few risk-relevant needs and progress scales, & limited research.*

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FUNDING OPPORTUNITY!

Department of Justice
Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

Assessing, Treating, & Managing Juveniles with Illegal Sexual Behavior: The Juvenile Treatment Progress Scale Development and Implementation Project

(2016-AW-BX-K004)

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A PARADIGM SHIFT

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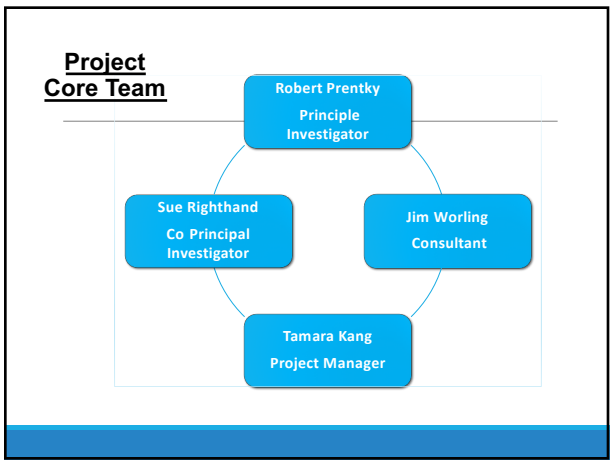

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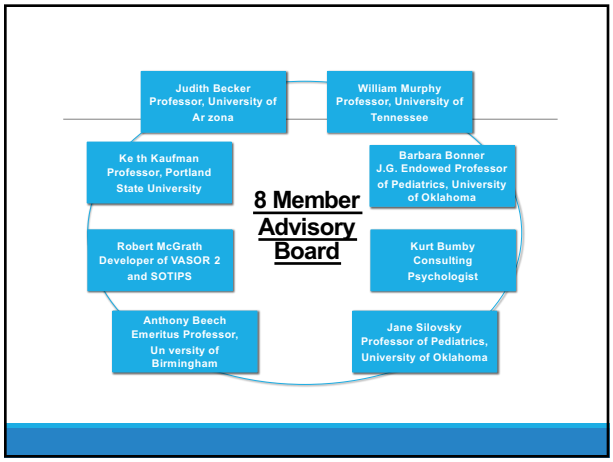

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PROJECT GOALS & OBJECTIVES

1. Design a developmentally sensitive, empirically informed, intervention needs & progress scale
   - *For Youth*
   - *& Young Adults,*

   with histories of sexually abusive or otherwise illegal sexual behavior.

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PROJECT GOALS & OBJECTIVES

2. Develop a scale that:
   - Builds on what we have learned,
   - Objectively describes potential risk and protective factors.
   - Includes individual & socioecological factors.
   - Is responsive to developmental changes & improvements.

➢ *Complements a well-integrated assessment that guides individualized and effective interventions.*

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PROJECT GOALS & OBJECTIVES

3. Train providers at five demographically and culturally diverse sites across the country on using the scale and incorporating it into their practices. Provide consultation support.
4. Test & evaluate the scale:
   - With 300-500 individuals,
   - Explore the utility of the scale in informing ongoing interventions,
   - Evaluate implementation successes & challenges.

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PROJECT GOALS & OBJECTIVES

4. Revise the test version of the scale in accordance with pilot feedback & experiences.
5. Facilitate implementation of a sustainable the revised version of the scale.

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THANK YOU!

You helped us accomplish many of our goals!

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SCALE STRENGTHS
(Feedback from all sites)

- *Generally easy to use.*
- *Gave focus and direction to treatment.*
- *Useful for treatment planning, identifying treatment goals, needed interventions, & progress.*
- *Helps the conversation regarding where treatment should go and how to help the youth who struggles.*
- *Useful for team meetings.*
- *Graphs provide nice visuals for treatment planning as well as communicating with clients/youth/families.*
- *Instead of just looking at the kid individually, the scale's focus can help encourage environment change that supports the youth's global needs.*

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CHALLENGES WITH THE SCALE
(Feedback from all sites)

Rating challenges:

- Items could be difficult to rate:
  - *Fine distinctions required.*
  - *Difficulties obtaining necessary information, especially detailed historical information.*
  - *Community settings differ from facilities.*
- Need clear & specific definitions to distinguish differences in treatment need.
  - *People viewed ratings differently. Easy to differentiate a 0 and a 3, but hard to sort out the in between.*
- Need to ensure consistency among raters.

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CHALLENGES WITH THE SCALE
(Feedback from all sites)

Challenges communicating findings:

- How do we communicate the scale to the community?
  - *How does it differs from a risk-assessment scale?*
  - *Need to know research support for items and rationale.*
- Need a way to view progress easily.
  - *Tables were pages and pages, and paper and pencil option took time.*
- Need to integrate the scale into agency current software system.

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CHALLENGES WITH THE SCALE
(Feedback from all sites)

Challenges using findings to guide interventions:

- Need help on using the scale to guide treatment.
  - *What do we do with the information once we see the treatment needs?*
  - *How can we use the scale to facilitate treatment in the milieu to help kids be successful?*
  - *How do we use the scale to refocus treatment with a youth who struggles?*

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IMPLEMENTATION CHALLENGES
(Feedback from all sites)

Challenges going forward

- How to manage work demands and time challenges?
  - *One site monitored and corrected implementation lapses.*
- Vacancies, leave of absences, & staff turnover.
  - *Increased usual workloads.*
  - *Need for new staff training.*
- How to ensure ongoing consistency among raters?
- How to address treatment needs, what concepts should be covered in treatment for specific needs?
- "The FAQ document was helpful."

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THANK YOU AGAIN

- Your feedback helped guide scale development, refinements, & improvement!

- The *Intervention Needs and Progress Scale (INPS)* is the revised version of the TNPS.

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SCALE OBJECTIVES

- Like the TNPS, the INPS is designed to assist clinicians, other service providers, and legal professionals reduce risk & stop offending by helping them:
  1. Identify risk-relevant intervention needs,
  2. Provide relevant & responsive interventions,
  3. Match intervention intensity to meet client need,
  4. Evaluate progress, revising treatment plans accordingly, & facilitating timely discharges.

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SCALE DEVELOPMENT: BUILDING BLOCKS

- Developmental immaturity & flux.
- Socio-ecological factors & context.
- Heterogeneity and individual differences.
- Recognizing strengths, not just challenges.
- *The RNR Model of Assessment & Crime Prevention Through Human Services*
  (c.f., Andrews & Bonta, 2010; Hoge, 2016; Hanson, Bourgon, Helmus, & Hodgson, 2009).

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ITEM SELECTION

- Reviews of the empirical literature re:
  - Onset of abusive sexual behavior
  - Risk and protective factors that may increase or decrease the likelihood of repeat offending.
  - Nonsexual recidivism
- Selected items that are:
  - Empirically based – related to offending
  - Theoretically grounded – relevant to those "at risk" and/or resilience following adversity.
- Consultations with Advisory Board
- Implemented the TNPS Test Version

(See Kang, et al., 2019 for a full discussion)

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TEST VERSION

- 18 *Historical* items, e.g.,
  - Criminal history, maltreatment experiences, placement instability.
- 27 *Dynamic* items:
  - Risk & Protective factors,
  - Intervention "responsivity" factors.
- Assessments conducted at intake and updated quarterly (or per policy),
- ➢ To guide interventions or discharge planning.

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27 Dynamic Treatment Targets (*Test Version*)		
1. Frequency of Sexual Thoughts	10. Law Abiding Behavior	19. Self-Efficacy
2. Sexual Interests	11. Attitudes & Beliefs (non-sexual rule violating & illegal behavior)	20. Compassion
3. Sexual Self-regulation	12. Peer Aged Friends	21. Coping with Sexual Abuse
4. Understanding Appropriate Sexual Behavior	13. Peer Associations	22. Coping with Nonsexual Negative Life Experiences
5. Understanding Consequences of Abusive Sexual Behavior	14. Relationship With Primary Caregiver (Client Perspective)	23. Attitudes Towards Interventions
6. Sexual Attitudes & Beliefs	15. Adult Mentors (Client Perspective)	24. Management Of Mental / Behavior Health Challenges
7. Behavior Self-Regulation	16. Social Skills	25. Supportive Caregiver or Significant Other
8. School / Work	17. Problem-solving	26. Stability in Living Situation
9. Free time	18. Emotion Regulation	27. Community Support

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ASSESSMENTS OVER TIME (All sites combined)

ALL SITES COMBINED	Frequency
INITIAL INTAKE	
1st Reassessment	
2nd Reassessment	
3rd Reassessment	
4th Reassessment	
5th Reassessment	
6th Reassessment	
7th Reassessment	
8th Reassessment	

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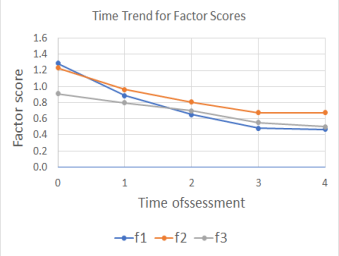
IMPROVEMENT OVER TIME

F1 - **Sexual self-management**
F2 - **General behavior self-management**
F3 - **Environmental factors and supports**



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PHASE 2: INPS DEVELOPMENT

- Reviewed site feedback.
- Performed a critical analysis of each item & the entire scale.
- ➢ *Shifted our focus exclusively to dynamic items:*
  - *That reflect recent and current intervention needs &*
  - *That can change as a function of intervention and/or maturation.*

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INPS DEVELOPMENT

- Rewrote items to be more clear and succinct.
- Revised item labels to better describe content.
- Streamlined the scale to reduce duplication.
- Improved scoring guidelines to provide better direction.
  - ***Positive feedback from site volunteers and Advisory Board reviews.***

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27 Dynamic Treatment Targets (*Test Version*)		
1. Frequency of Sexual Thoughts	10. Law Abiding Behavior	19. Self-Efficacy
2. Sexual Interests	11. Attitudes & Beliefs (non-sexual rule violating & illegal behavior)	20. Compassion
3. Sexual Self-regulation	12. Peer Aged Friends	21. Coping with Sexual Abuse
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6. Sexual Attitudes & Beliefs	15. Adult Mentors (Client Perspective)	24. Management Of Mental / Behavior Health Challenges
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8. School / Work	17. Problem-solving	26. Stability in Living Situation
9. Free time	18. Emotion Regulation	27. Community Support

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INPS DEVELOPMENT

- Factor Analyses of test version ratings. Findings indicated three empirically derived subscales.
  - F1 - Sexual self-management
  - F2 - General behavior self-management
  - F3 - Environmental factors and supports
- Two additional items related to treatment response are included in the revised *22-item scale*.
  - Mental Health Management
  - Participation in Interventions (formerly Attitudes toward Intervention)

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INPS: INTENDED POPULATIONS

- Youth and young adults (12 to 25).
  - *If used with pubescent 10 or 11 year olds, those using the scale are responsible for justifying its use (e.g., maturation).*
- Research regarding females guided scale development but,
  - *Only of 5 of 605 individuals assessed with the INPS were female!*

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INPS: INTENDED USE

- The INPS is designed to complement a well-integrated initial and reassessments.
  - *Varied sources of information typically inform clinical and forensic assessments and intervention plans.*

➢ *It should not be necessary to collect information for the sole purposes of rating this scale.*

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INPS RATING TIMEFRAMES

- All INPS assessments focus on the Past 3 months to address current intervention needs.
- The initial INPS occurs as part of an intake assessment, ideally, once sufficient information is available.
- Reassessments are conducted every 3-months *(more frequently if appropriate or required*).
- Discharge INPS assessments are recommended.

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4 – POINT ORDINAL RATING SCALE

The INPS ranges from "0" or "no intervention need" apparent during the assessment period to "3" or strong "need".

The focus on intervention shifts the primary emphasis from risk to the central focus on the "needs" that must be addressed to mitigate risk and stop offending.

0 No Intervention Need.
1 Possible/Limited Intervention Need.
2 Moderate Intervention Need.
3 Strong Intervention Need.

40

KEY RATING DIFFERENCES

- **0** and **1** ratings indicate that positive features of the item are regularly or usually present.
  - *Some relatively minor problematic behaviors may be developmentally normative.*
- **2** and **3** ratings reflect challenges, difficulties, problems, and sometimes failures that may contribute to further negative outcomes.
  - *Intervention is clearly indicated!*

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UPDATED FREQUENCY TERMS

RATING	FREQUENCY TERM	DEFINITION
0	*Regularly* positive.	No problems noted during this period.
1	*Usually* positive, *with no more than a few minor exceptions*.	Problems rarely noted during this period, except for a small number of minor instances.
2	*Occasionally* concerning.	Problems noted periodically during this period.
3	*Often* concerning.	Problems noted frequently during this period. Problems appear typical for the client.

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FREQUENCY & SEVERITY RATING CONSIDERATIONS

- *Frequency* may indicate the magnitude of a difficulty and the extent to which an intervention is needed.
- Sometimes the *severity* of a problem, (e.g., harm to self or others, destruction of property), may be more important than how often the problem occurs and may override a frequency rating.

43

WHAT IF?

- What if the domain was positive most of the assessment period, but then deteriorated?
  - ➢ *Rate for current treatment need*.
- What if the domain was concerning early in the quarter, but now is improved?
  - ➢ *Consider the full 3 months; may select a rating reflects this improvement but also the recent concern.*

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?

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THE INTERVENTION NEEDS AND PROGRESS SCALE

(AKA: INPS) Part 2

Product of DOJ Grant # 2016-AW-BX-K004: *Assessing, Treating And Managing Juveniles With Illegal Sexual Behavior: The Juvenile Treatment Progress Scale Development And Implementation Project Awarded To Fairleigh Dickinson University.*

Presentation by: Sue Righthand, Ph.D., Fall 2019
sue.righthand @gmail.com

1

CONDUCTING ASSESSMENTS

- *Confidence in assessment findings is increased when information is expressed:*
  - *In multiple ways (e.g., statements, actions).*
  - *Is observed by multiple sources, and*
  - *In multiple contexts.*
- ***Consider multiple sources of information!***
- ***Use multiple methods of assessment!***

2

RELEVANT INFORMATION INCLUDES:

- Pertinent records and assessments,
- Prior INPS findings,
- Current service provider case notes, family and/or milieu and adjunct program staff reports, treatment progress notes or summaries,
- Focused client interviews,
- Treatment participation & observations.

3

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KEY RATING GUIDELINES

- ***All items must be considered in a developmental context.*** Consider individual strengths and challenges in view of what is socially, emotionally, and cognitively typical of individuals of a similar age and developmental stage.
- ***Ratings are based on all relevant and credible information for the appropriate time period.***
- ***Rate conservatively.*** When the information appears incomplete, but enough to rate, go with the "lower" rating.
- ***Opt not to rate and gather more information.*** If available information is clearly insufficient for a reliable rating, check "unable to rate" on the Rating Form.

4

USE RATING GUIDE

Intervention Needs and Progress Scale (INPS)

Product of DOJ Grant # 2016-AW-BX-K004: *Assessing, Treating And Managing Juveniles With Illegal Sexual Behavior: The Juvenile Treatment Progress Scale Development And Implementation Project Awarded To Fairleigh Dickinson University.*

5

Intervention Needs and Progress Scale Rating Form

Name: _____ ID # _____ DOB: _____

Initial ___ Reassessment ___ Discharge ___ Number 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. Commitment to School / Work	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. Current View of Primary Caregiver Relationship	0	1	2	3	
17. Current 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	

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EXCEL

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

7

HOW DO WE USE THE RATINGS?

8

R-N-R MODEL of Assessment & Crime Prevention Through Human Services

CORE PRINCIPLES:

- Risk Principle
  - *Focus: Those with most risks, fewest protective factors (i.e., greatest risk-relevant needs).*
- Need Principle
  - *Focus: Dynamic criminogenic factors (needs).*
- Responsivity Principle
  - *Focus: Factors that enhance treatment response; consider relevant, individual/family characteristics.*

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R-N-R MODEL RESEARCH SUPPORT

- Support with general criminal behavior, (e.g., Andrews & Bonta, 2010; Andrews, Bonta, & Hoge, 1990; Bonta & Andrews, 2016; Smith, Gendreau, & Swartz, 2009).
- Support for juveniles, (e.g., Hawkins et al., 1998; Hoge, 2016, Lipsey, 1995; Lipsey, 1999, Pealer & Latessa, 2004).
- Support for sex offense specific treatment, (e.g., Hanson, Bourgon, Helmus, & Hodgson, 2009).

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R-N-R MODEL - *AN ASSESSMENT GUIDE*

- Risk: *Identify static & dynamic risk and protective factors.*
- Need: *Evaluate risk-relevant dynamic factors (criminogenic needs).*
- Responsivity: *Assess factors that may impede / facilitate treatment engagement & participation, learning & positive change.*

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R-N-R MODEL - *AN ASSESSMENT GUIDE*

- Assess R-N-R *using structured and validated instruments.*
- Assess personal strengths:
  - *Integrate them into interventions.*
- Assess noncriminogenic needs that may be barriers to prosocial change while maintaining a focus on RNR factors.
- Use professional discretion for specified reasons.

(Andrews, Bonta, & Wormith, 2011)

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R-N-R MODEL - *AN INTERVENTION GUIDE*

- *Who? Engage those with the most risk factors and fewest protective ones.*
- *What? Criminogenic Needs.*
  - Reduce risk factors,
  - Enhance protective ones.
- *How? Responsive interventions. Matched to individual & family learning styles / characteristics.*

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Intervention Needs and Progress Scale Rating Form

Name: _____ ID # _____ DOB: _____
Initial ____ Reassessment ____ Discharge ____ Number 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. Commitment to School / Work	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. Current View of Primary Caregiver Relationship	0	1	2	3	
17. Current View of Supportive Adult Relationships	0	1	2	3	
18. Family Functioning	0	1	2	3	
19.Living Situation Society & 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 of ratings endorsed by column Number of 0's 1's 2's 3's & unable to rate					

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Proportion of Intervention Need By Strength: Summary Form

Proportion of ratings of 0;
No Intervention Needs _____%
[Number of items rated 0 / Total number of items rated]

Proportion of ratings of 1;
Possible/Limited Intervention Needs _____%
[Number of items rated 1 / Total number of items rated]

Proportion of ratings of 2;
Moderate Intervention Needs _____%
[Number of items rated 2 / Total number of items rated]

Proportion of ratings of 3;
Strong Intervention Needs _____%
[Number of items rated 0 / Total number of items rated]

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Proportion of Intervention Need By Strength: Summary Form (Cont.)

Proportion of No or Possible/ Limited Intervention Needs _____%
[Number of items rated 0 or 1 / Total number of items rated]

Proportion of Moderate or Strong Intervention Needs _____%
[Number of items rated 2 or 3 / Total number of items rated]

16

PLEASE DON'T FORGET

- **Proportion of items checked "unable to rate"** _____%

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EXCEL

INDIVIDUAL INTERVENTION NEEDS

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

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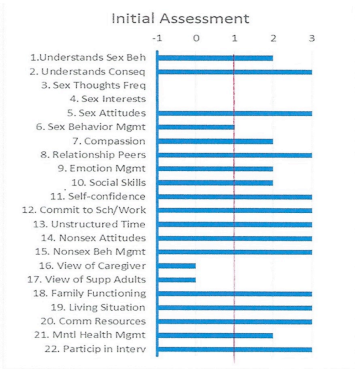

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LINKING RATINGS TO INTERVENTIONS

RATING	INTERVENTION NEED
0	No intervention needed.
1	No intervention may be needed, or a brief intervention may help correct a minor problem and/or facilitate, reinforce or strengths and protective factors. .
2	Requires appropriate intervention.
3	Requires intensive intervention

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EXCEL

REASSESSMENT OVER TIME

Item	Initial Assessment	Reassessment T1	Reassessment T2	Reassessment T3	Reassessment T4
1. Understanding Appropriate Sexual Behavior	2	2	1	0	0
2. Understanding the Consequences of Sexual Abuse	3	2	2	0	0
3. Sexual Thoughts - Frequency	-1	0	0	0	0
4. Sexual Interests - Age & Consent	-1	0	0	0	0
5. Sexual Attitudes & Beliefs	3	2	2	1	0
6. Sexual Behavior Management	1	1	0	0	0
7. Compassion for Others	2	2	2	1	1
8. Relationships with Peers	3	3	2	1	1
9. Emotion Management	2	2	2	1	0
10. Social Skills	2	2	1	1	0
11. Self-confidence	3	2	2	1	1
12. School & Work Commitment	3	2	2	0	0
13. Use of Unstructured Time	3	2	2	0	0
14. Nonsexual Behavior Attitudes & Beliefs	3	3	2	1	1
15. Nonsexual Behavior Management	3	3	2	1	0
16. Client View of Primary Caregiver Relationship	0	2	2	1	1
17. Client View of Supportive Adult Relationships	0	1	2	1	0
18. Family Functioning	3	2	2	1	1
19. Living Situation - Safety & Stability	3	2	2	2	2
20. Involvement in Community Resources	3	2	2	1	0
21. Mental Health Management	2	2	1	1	1
22. Participation in Interventions	3	2	1	0	0

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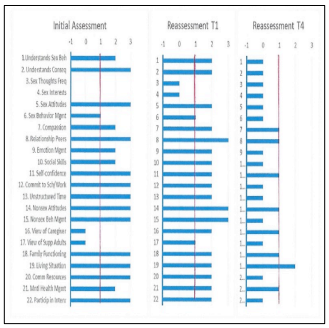
REASSESSMENT OVER TIME



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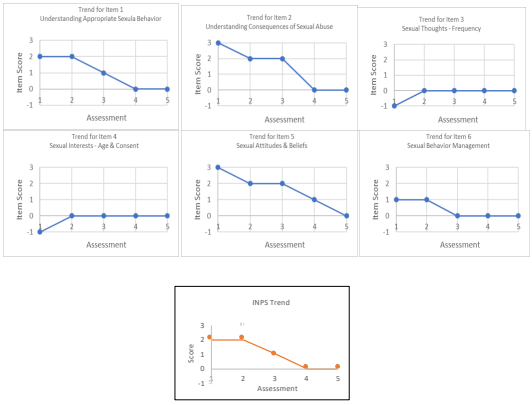
EXAMPLES: TRENDS OVER TIME



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SO HOW AM I SUPPOSED TO DO ALL THIS?

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IMPLEMENTATION

- There are challenges.
- Require ongoing discussions.
- An assessment (FAQ) manual will follow.

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EFFECTIVE INTERVENTIONS ARE UP TO US!

- INPS assessments can help us objectively identify:
  - Relevant treatment targets,
  - Intervention intensity,
  - Appropriate service delivery.
- By assessing progress, we can revise intervention and treatment plans as needed.
- We can also evaluate and demonstrate positive client & program outcomes.
- ➢ But, we often don't do works!
  (Viljoen, Cochrane, & Jonnson, 2018)

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EFFECTIVE INTERVENTIONS ARE UP TO US!

- ➢ The use of risk & needs assessment scales is variable (Viljoen et al., 2018).
- ➢ When used:
  - Match to the Risk Principle was moderate,
  - Match to the Need Principle was limited.
- ➢ When findings were used, they general informed early decisions, and were not used to match needs over time.
- ➢ ***Risk and needs assessment scales are likely to be of value only if we use them appropriately!***

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RESOURCES

- National Center on Sexual Behavior of Youth: www.ncsby.org
- Association for the Treatment of Sexual Abusers: www.atsa.com
- Washington State Institute for Public Policy: http://www.wsipp.wa.gov/BenefitCost
- California Evidence-Based Clearinghouse for Child Welfare: www.cebc4cw.org/
- Blueprints for Healthy programs - Formerly Blueprints for Violence Prevention - http://www.blueprintsprograms.com/
- Center for Sex Offender Management: www.csom.org

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Appendix B: Program to Track Progress Over Time

EXCEL

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

INDIVIDUAL INTERVENTION NEEDS

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

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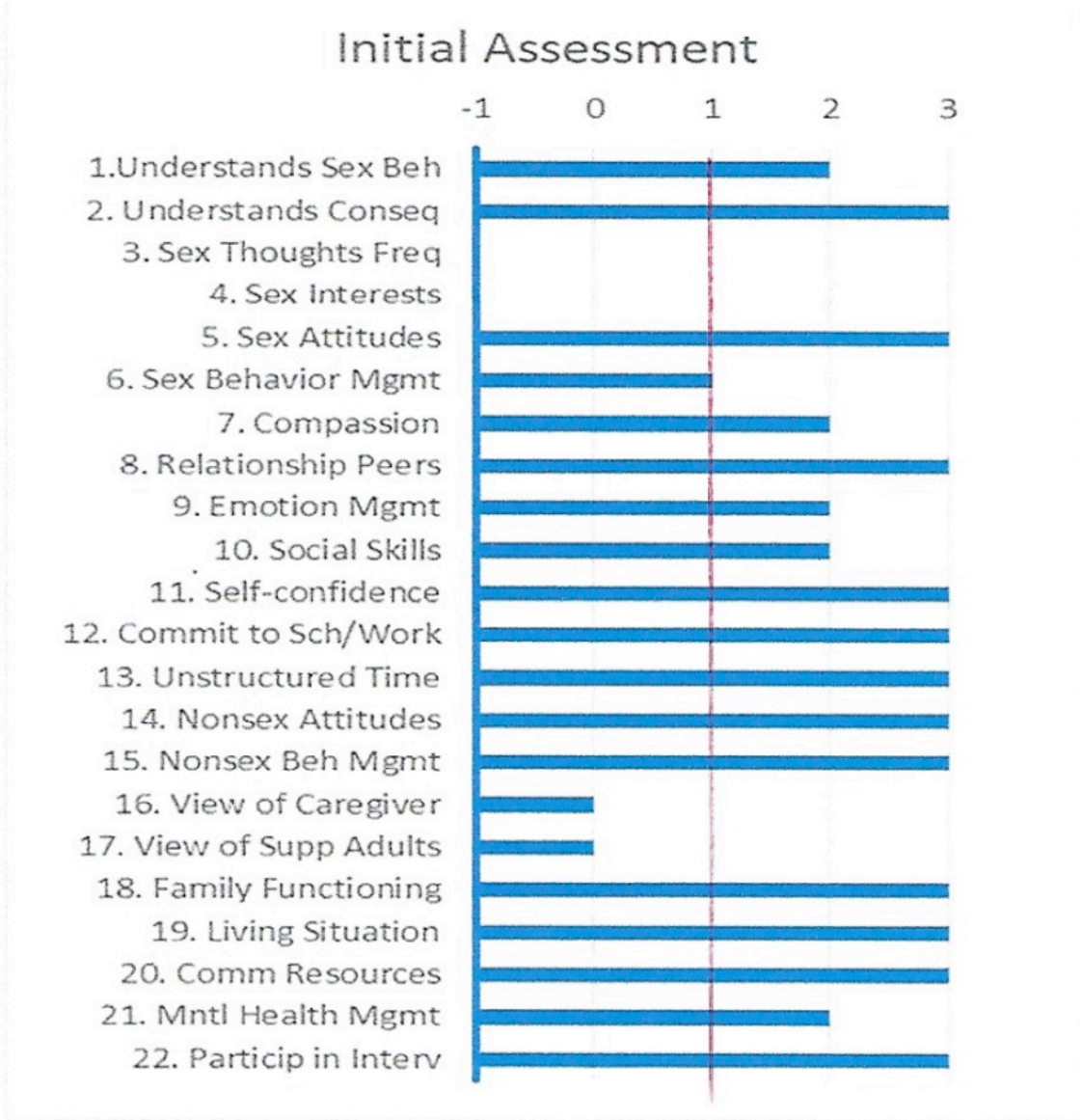

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REASSESSMENT OVER TIME

Item	Initial Assessment	Reassessment T1	Reassessment T2	Reassessment T3	Reassessment T4
1. Understanding Appropriate Sexual Behavior	2	2	1	0	0
2. Understanding the Consequences of Sexual Abuse	3	2	2	0	0
3. Sexual Thoughts - Frequency	-1	0	0	0	0
4. Sexual Interests - Age & Consent	-1	0	0	0	0
5. Sexual Attitudes & Beliefs	3	2	2	1	0
6. Sexual Behavior Management	1	1	0	0	0
7. Compassion for Others	2	2	2	1	1
8. Relationships with Peers	3	3	2	1	1
9. Emotion Management	2	2	2	1	0
10. Social Skills	2	2	1	1	0
11. Self-confidence	3	2	2	1	1
12. School & Work Commitment	3	2	2	0	0
13. Use of Unstructured Time	3	2	2	0	0
14. Nonsexual Behavior Attitudes & Beliefs	3	3	2	1	1
15. Nonsexual Behavior Management	3	3	2	1	0
16. Client View of Primary Caregiver Relationship	0	2	2	1	1
17. Client View of Supportive Adult Relationships	0	1	2	1	0
18. Family Functioning	3	2	2	1	1
19. Living Situation - Safety & Stability	3	2	2	2	2
20. Involvement in Community Resources	3	2	2	1	0
21. Mental Health Management	2	2	1	1	1
22. Participation in Interventions	3	2	1	0	0

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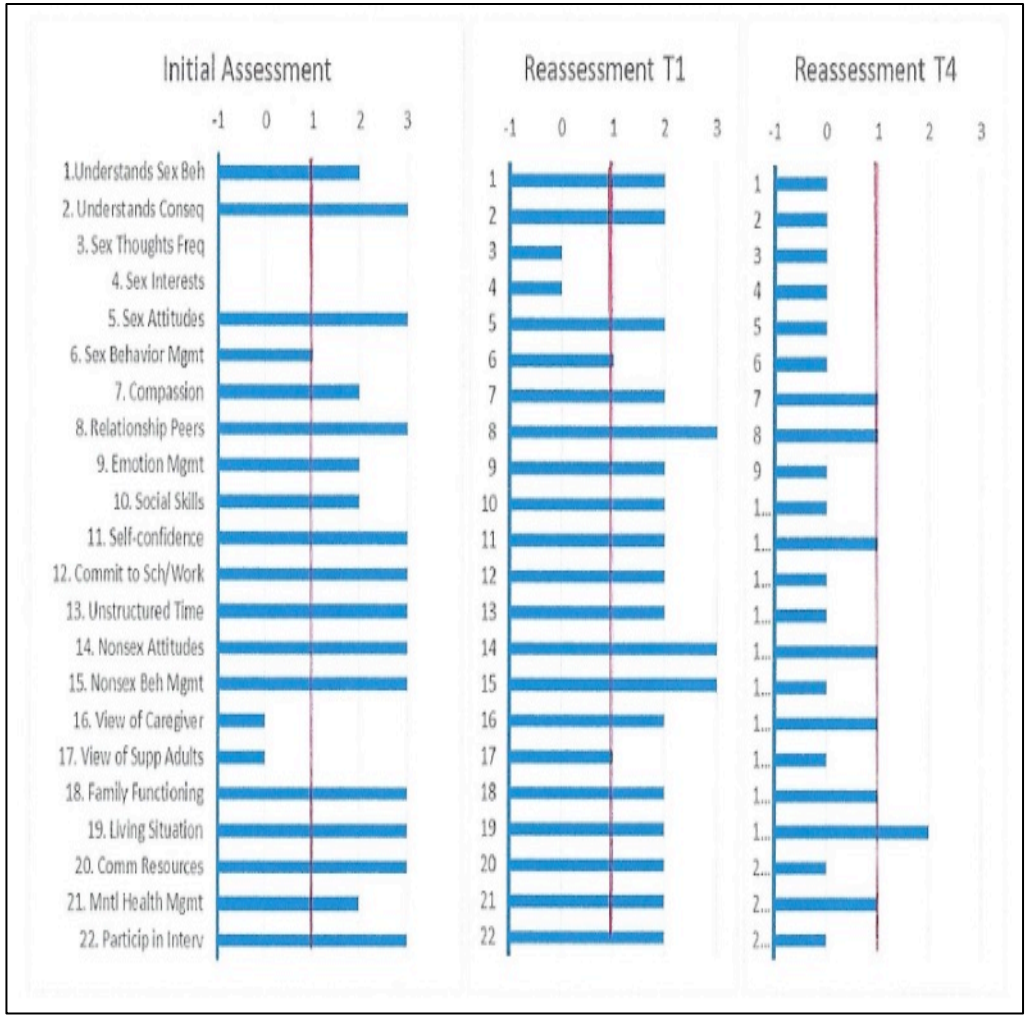
REASSESSMENT OVER TIME



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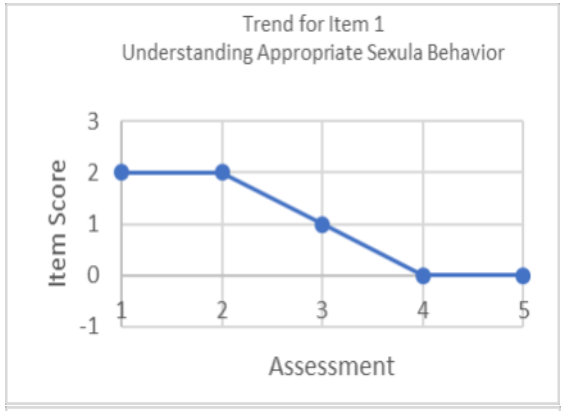
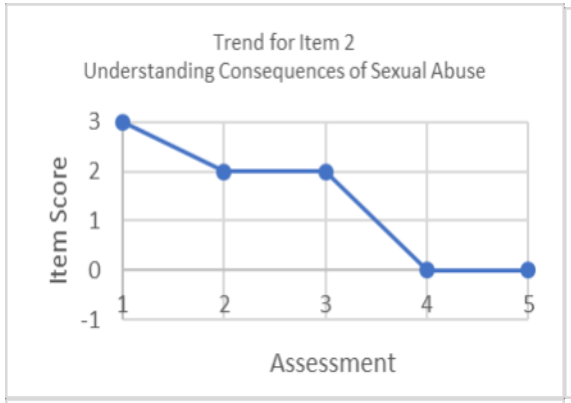
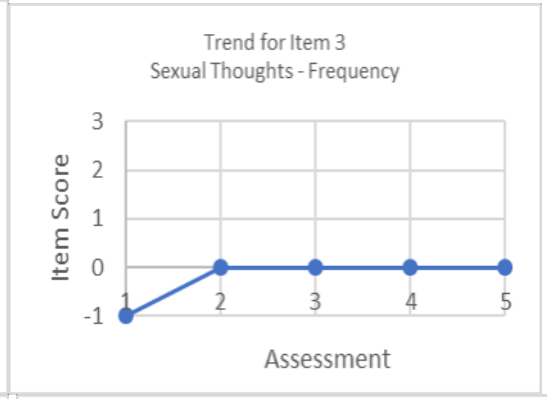
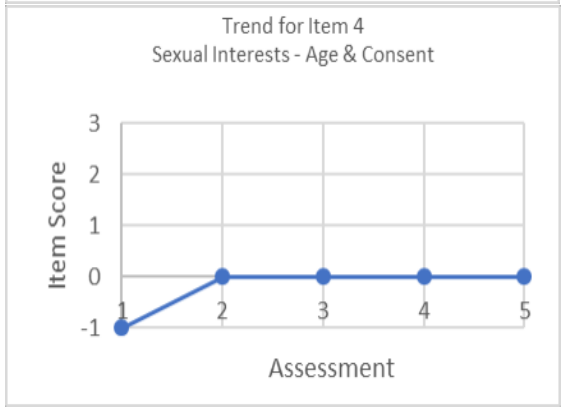
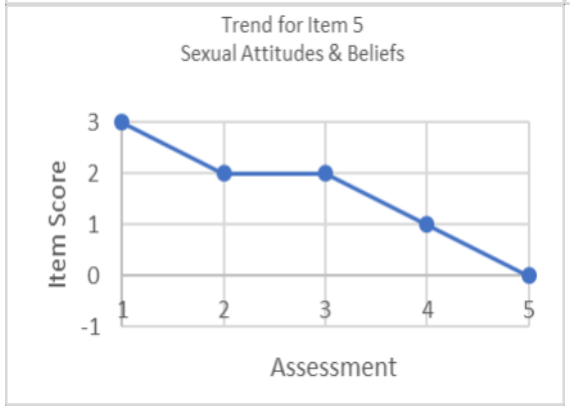
EXAMPLES: TRENDS OVER TIME

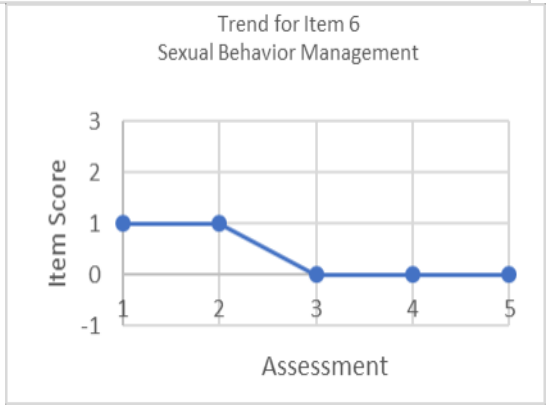


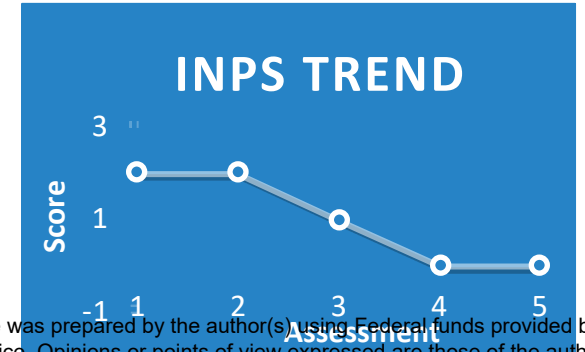












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Appendix C: User Manual & Scale

Youth Needs and Progress Scale

&

User Guide

Sue Righthand Ph.D.
James R. Worling, Ph.D.
Robert A. Prentky, Ph.D.
Tamara Kang, Ph.D.

2020

This Youth Needs and Progress Scale and User Guide is a work product for the project funded by the United States Department of Justice (DOJ), Office of Justice Programs [Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking; SMART Office] through grant # 2016-AW-BX-K004 and does not necessarily reflect the views of the SMART Office or the DOJ.

[Grantee: Fairleigh Dickinson University, Teaneck, N.J. Principal Investigator: R. A. Prentky]

Youth Needs and Progress Scale (YNPS)

Table of Contents

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Youth Needs and Progress Scale (YNPS)

Introduction

The Youth Needs and Progress Scale (YNPS) is a 22-item rating scale designed to help identify risk-relevant intervention needs, and track progress toward resolving those needs, among individuals aged 12 to 25 who have engaged in abusive sexual behavior. *Abusive sexual behavior* includes contact or noncontact nonconsenting, coercive, and/or assaultive sexual activities and sexual behavior involving significantly younger persons (generally defined as someone who is at least 4 years younger). Any underage sexual activity that has been or could be charged as a sexual offense is included in this definition as well.

Because nonsexual reoffending typically exceeds rates of sexual reoffending among individuals with abusive sexual behavior, factors associated with sexual and nonsexual offending are included in the YNPS. More specifically, empirically-informed individual, social, and environmental risk and protective factors associated with offending and circumstances and influences that may facilitate or interfere with treatment engagement and response are included in this scale.

In view of the developmental flux in youth and emerging adults, and fluctuations in life circumstances, the YNPS focuses specifically on dynamic items to capture these changes. For this reason, it is recommended that reassessments be conducted at least every three months to identify possible changes and adjust interventions accordingly.

Although the YNPS may be useful as a measure of intervention needs as part of a risk and needs evaluation, it is not a "risk assessment" scale, per se. Its purpose is <u>not</u> to predict re-offense risk.

As with other assessment scales, this scale cannot include every potential risk-relevant factor and consideration. It is intended to be used as component of a comprehensive assessment that considers an array of risk-relevant individual, social, and environmental factors. Given its focus on dynamic factors, assessments and resulting clinical, case, and legal decisions must not be based on the YNPS alone.

Development of the Youth Needs and Progress Scale

The Youth Needs and Progress Scale (YNPS) was developed as the primary work product of the *Assessing, Treating and Managing Juveniles with Illegal Sexual Behavior: The Juvenile Treatment Progress Scale Development and Implementation* grant (DOJ Grant # 2016-AW-BX-K004) awarded to Fairleigh Dickinson University. The goals and objectives of this three-year project included creating an empirically informed risk-relevant needs and progress scale and integrating it at diverse juvenile sexual offense-specific treatment programs around the United States to examine its utility. Feedback and findings from this implementation phase of the project were instrumental for improving and refining the pilot version of the scale and developing this Youth Needs and Progress Scale (YNPS). Details of the project are presented and discussed in Kang, et al., (2019) and in the Final Report (DOJ Grant # 2016-AW-BX-K004) to the U. S. Department of Justice, Office of Justice Programs, Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering and Tracking.

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Training and Qualifications

User qualifications have more to do with relevant training and experience than a particular degree. Those who use this scale should:

- Be aware that adolescents and young adults who engage in abusive sexual behavior are a heterogeneous group.
- Be conversant with adolescent and young adult development.
- Be knowledgeable about factors that contribute to and/or may mitigate abusive sexual behavior and other types of offending.
- Understand that sexual re-offense rates are typically low, while rates of nonsexual reoffending are generally higher.
- Be familiar with relevant evidenced-based interventions.

User guidelines include the following:

- Read and use this User Guide.
- Complete several practice cases and compare ratings with others who have rated the same case to identify and then discuss and resolve any differences.
- Confer with others periodically to assist with rating items reliably.

As with any scale, those who use this scale should be well versed in the strengths and limitations of the measure and ensure constraints are clearly articulated.

Intended Population

This scale was developed following a literature review of factors associated with the onset, continuation, and cessation of abusive sexual behavior and nonsexual offending among male and female adolescent and adult populations. Research indicates that changes in youth development typically stabilize in the mid-twenties; therefore, the YNPS is considered suitable for individuals aged 12 to 25. Further, this scale was developed to be flexible enough to be used with males and females. The question of using this scale with non-cisgender clients is fundamentally an empirical one; however, there is no research to suggest this scale would not be appropriate for a full spectrum of gender identities.

Applications

This scale is designed to assist clinicians, probation officers, forensic evaluators, the courts, and other service providers and decision makers in:

- Identifying risk-relevant intervention needs,
- Prioritizing appropriate intervention strategies,
- Monitoring progress toward resolving identified needs,
- Facilitating case and/or treatment plan revisions according to current needs, and
- Evaluating the completion of interventions and readiness for discharge.

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In addition to the scale's utility with individual clients, it may be useful for program evaluations. For example, client data can be aggregated and compared at different points in time (e.g., intake and discharge), and ratings may be examined in terms of their association with various outcomes, such as positive life achievements and accomplishments and, of course, remaining crime free.

Rating Procedures

Relevant Information:

Because the YNPS is intended to be used as part of a comprehensive assessment, information that is typically collected to inform assessments of youth and emerging adults with histories of abusive sexual behavior may be useful for rating scale items. In addition to interviews and documents that provide information across multiple settings, psychological measures can also add important information. It should not be necessary to collect information for the sole purposes of completing the scale.

Developmental Consideration:

When rating the frequency and/or severity of an item, it is critical to consider what is socially, emotionally, and cognitively typical of individuals of a similar age and developmental stage. For example, compared to a 17-year-old client, a 12-year-old client would usually have less detailed knowledge of laws regarding sexual behavior and consent. Similarly, social skills generally look very different for an 18-year-old compared to a 13-year-old. Although developmentally different skill sets are expected, if problems are present, they should be rated as intervention needs.

Rating Timeframes:

Initial YNPS ratings and reassessments are based upon client functioning during the past three (3) months. Clients can be re-assessed at shorter intervals per agency policy and/or client need. To be most time-efficient, YNPS assessments and reassessments can be timed to coincide with other routine reassessments and client reviews, such as treatment planning updates and/or multidisciplinary team meetings.

Completing the scale may facilitate discharge summaries by helping to document progress and any areas requiring further intervention. If a client is transferred to a new provider within an agency, a new assessment upon arrival may not be necessary; the client may simply be reassessed consistent with the agency's policies.

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Definitions:

Language and scaling:

YNPS ratings are based on the relative presence or absence of risk and protective factors. Instead of relying on conventional binary (present, absent) or 3-level (0, 1, 2) ratings, in which the "1" is an ambiguous rating for "unclear" or not fully present or absent, that are used in most risk assessment scales, the YNPS uses a 4-level ordinal scale (0, 1, 2, 3). All four ratings are designed to be unique and independent in terms of the information conveyed about the client and the degree of intervention need. The word "need" in this scale shifts the primary focus of risk and needs assessment from risk "prediction" to risk mitigation by identifying intervention needs that, when effectively addressed, may eliminate, reduce, or modify risks and promote protective factors.

Frequency Ratings:

Ratings generally rely on frequency to indicate the magnitude of a problem. Ratings and frequency terms are defined as follows.

RATING	FREQUENCY TERM	DEFINITION
0	*Regularly* positive.	No problems noted during this period.
1	*Usually* positive, with no more than a few minor exceptions.	Problems rarely noted during this period, except for a small number of minor instances.
2	*Occasionally* concerning.	Problems noted periodically during this period.
3	*Often* concerning.	Problems noted frequently during this period. Problems appear typical for the client.

Severity overrides:

For some items, the severity of a problem (e.g., harm to self or others and/or costly destruction of property) may be more important than how often it occurs and may override a frequency rating. For example, aggression resulting in physical injury, or even a credible threat to harm, may result in an item being rated a two (2) or three (3), even if it has occurred only once during the rating period. Behaviors that cause physical injury to self or others are usually rated a 3, unless the behavior occurred early in the rating period and the client's behavior is improved, in which case a rating of 2 may be indicated.

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Rating Guidelines

Rate items reliably:

Rating "reliably" means that you are reasonably confident in your rating. To rate reliably, it is critical to understand the differences between 0 & 1, 1 & 2, and 2 & 3.

- A rating of zero (0) indicates that the client regularly demonstrates the positive characteristics described in the item and/or no problems were evident during the rating period.

- A rating of one (1) indicates that the client usually demonstrates the positive characteristics of the item, allowing for up to "a few relatively minor exceptions" and excluding severe behavior problems or moderate or strong concerns.

- A rating of a two (2) indicates that the client sometimes demonstrates positive features of the item, but problems occur occasionally, or one or more severe problems have occurred, but not so severe as to warrant a rating of three (3).

- A rating of three (3) indicates that problems are often noted. This rating may also be warranted when there have been one or more severe problems that were particularly egregious (e.g., significant injury to others, a serious suicide attempt, or substantial property damage).

➢ *Key differences between a 0 and a 1 compared with a 2 and a 3:*

- **0** and **1** ratings are generally positive. They reflect an absence of significant concerns and may indicate protective factors that help mitigate risk.

- **2** and **3** ratings are concerning in that they reflect challenges, difficulties, and problems that may contribute to further negative outcomes.

➢ *Key differences between a 0 and a 1:*

- **0:** A rating of 0 applies when all aspects of the rated item *regularly* reflect the presence of positive characteristics as described in the item. A rating of 0 suggests that a treatment need does not currently apply.

- **1:** A rating of 1 applies when aspects of the rated item *usually* reflect the presence of positive characteristics as described in the item.

  In sum:

- Some concerning behaviors occur in ratings of 1, but they are not frequent or severe, and they are <u>not</u> developmentally unexpected.

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- Positive characteristics of the item are not consistently present in ratings of 1 compared to ratings of 0.

- With ratings of 1, brief or limited interventions may be beneficial to reduce the likelihood of reoccurrences that could lead to further trouble, but they may not be necessary.

➢ *Key differences between a 1 and a 2:*

- **1**: A rating of 1 only applies when there are **no** moderate or strong problems or concerns.

- **2:** A rating of 2 implies some moderate problems or concerns that exceed developmental expectations due to the nature, the frequency, or the severity of those problems. Problems occur *occasionally,* although even one or two serious indicators may warrant a 2.

In sum:
- Compared with a rating of 1, a rating of 2 reflects more significant challenges and difficulties that clearly require intervention.

➢ *Key differences between a 2 and a 3:*

- **2:** Concerns are noted *occasionally* but do not reflect a pattern that appears characteristic of the client.

- **3:** Concerns are noted *often* and reflect a pattern that appears typical of the client. Concerns may also be due to how severe or chronic the problem or behavior is.

In sum:
- Compared with a rating of 2, a rating of 3 reflects more significant challenges and difficulties, and these issues generally occur more frequently and/or result in physical injury and/or costly property destruction. Such ratings reflect the need for well-targeted case plans, with ratings of 3 typically requiring more intensive interventions.

Rating reminders:

➢ *Rate each item based on all relevant and credible information for the appropriate time period* (past 3 months*).*

➢ *Rate conservatively*. When the information appears to be incomplete or insufficient, but a rating is possible, rate conservatively. As a rule, a conservative rating would be the "lower" rating for that item (e.g., if unsure between a two (2) and three (3), go with a two (2)).

➢ *Opt not to rate.* Ratings should be completed only when there is sufficient information. If information is insufficient for a reliable rating, check "unable to rate" on the Rating Form. Additional information may be obtained over time enabling a more compete assessment.

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Charting Progress

A strength of the YNPS is that it can be used to monitor progress during interventions over time. Several rating forms are provided in this User Guide following the scale items. These forms can be used for rating scale items during each assessment and for comparing findings.

In addition, automated software programs, such as Excel, can be programmed so assessment and reassessment ratings can be entered and also displayed in tables and graphs that can illustrate changes in ratings over time. Visual illustrations of treatment needs and progress may assist treatment and other service providers in identifying and addressing needed areas of intervention. Tables and graphics may also help clients and families recognize accomplishments and areas for improvement, and assist multi-disciplinary team members, the courts, and other legal decision makers develop case plans that promote desistance from offending.

Linking Ratings to Interventions

Scale ratings can be helpful for developing case and treatment plans that address identified needs. Following the initial assessment, reassessments may point to areas of progress or, conversely, continued or increased difficulties. Such information may suggest whether interventions should be continued, changed or, when appropriate, concluded.

As noted in the table below, item ratings suggest the extent to which intervention may currently be needed.

RATING	INTERVENTION NEED
0	No intervention needed.
1	No further intervention needed, or a brief intervention to help correct a minor problem and/or facilitate and/or reinforce strengths and protective factors.
2	Requires appropriate intervention.
3	Requires intensive intervention

Individualizing Case & Treatment Plans

Risk-Need-Responsivity (RNR) Model:

Consistent with the Risk-Need-Responsivity (RNR) model (e.g., Andrews & Bonta, 2010), clients who have many intervention needs, (i.e., many 2's and 3's), may require more intensive interventions that provide good support and supervision (e.g., frequent appointments and treatment sessions throughout the week and a longer duration of services). Clients who have few intervention needs, (i.e., a large proportion of 0's and 1's) may need limited interventions (e.g., possibly short-

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term treatment and weekly sessions) or, perhaps, no interventions beyond what they have already experienced. Reviews of the rating scale summary forms may help make such determinations.

Individual Scale Item Ratings:

When designing treatment and case plans, specific item ratings may help identify current intervention needs. Identified needs may indicate appropriate intervention strategies that can help address the client's needs. For example, interventions that have been shown to be effective for helping clients address emotion management problems may be recommended or provided when Emotion Management has been identified as a moderate or strong need.

There may be instances when a 0 (No Need) or a 1 (Possible or Limited Intervention Need) is rated and interventions appear warranted. For example, although a rating of "0" indicates that no need for intervention was noted during the rating period, the domain may have previously been rated as a concern. In such cases, a longer period of support and monitoring may be justified to ensure continued positive functioning. In such an instance, the rating of 0 should not be changed if it accurately reflects what was observed during the most recent rating period, but the possible need for further support and monitoring can be added to the client's case or treatment plan.

By definition, up to a few minor problems may be indicated by a rating of a 1. These difficulties may be developmentally normative (e.g., inappropriate sexual comments, underage drinking), but if such behaviors continue, they may result in the client getting into further trouble. Thus, interventions may be recommended or provided when a 1 is rated to address minor behavior problems, to maintain or increase strengths, and promote possible protective factors (e.g., enhance available supports and supervision).

Patterns indicated by item ratings:

In addition to using specific items to identify intervention needs, patterns and groupings of items may indicate a need for a specific type of intervention. For example, some clients may have moderate and strong intervention needs on general behavior management items, but not on items specific to abusive sexual behavior. These individuals may benefit most from interventions that specifically address antisocial thinking and behavior management. Conversely, some clients may have limited general behavior problems, but evidence moderate to strong intervention needs with respect to their current sexual thoughts, attitudes, and behaviors. These individuals may benefit from interventions more focused on healthy sexual attitudes and behavior. Further, when caregiver support and family functioning are moderate or strong treatment needs, those areas will warrant intervention.

Considering other factors:

When developing case and treatment plans, an array of risk-relevant historical factors and dynamic influences not included in the scale require consideration. For example, it is possible that various sources of information may suggest that a client with a history of violent offending that precedes the 3-month YNPS rating timeframe may benefit from more intensive services, in spite of appropriate self-management in recent months.

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There may also be individual or family characteristics that suggest particular treatment approaches or styles may be best. For example, clients with cognitive challenges and/or developmental disabilities may benefit most from interventions that are tailored to their individual learning styles. In general, interventions that consider age and development, religious and cultural preferences, gender, and other individual and/or family characteristics may be more effective than those that do not take these factors into consideration.

Importantly, case and treatment plans must be realistic, and the availability of appropriate services must be considered. Interventions should be prioritized to adequately address client needs and maximize safety, yet not overwhelm the client and family members with too many appointments, commitments, and expenses. To the extent possible, case and treatment plans should be individualized to appropriately meet client needs and maximize the likelihood of success.

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Youth Needs and Progress Scale

1. Understanding Appropriate Sexual Behavior

***Definition*: Good understanding of appropriate sexual behavior involves awareness of society's sexual behavior expectations and laws. Poor understanding of appropriate sexual behavior may be reflected in a lack of knowledge of what is considered consensual and legal sexual behavior.**

NOTE:

- Understanding what is appropriate sexual behavior does not always translate into engaging in proper and legal behavior. For example, understanding but disregarding rules for appropriate sexual behavior should be rated in Item 6 (Sexual Behavior Management). This item is only concerned with how well the client understands what is appropriate sexual behavior.

Current Rating (past 3 months):

0 = No Intervention Need	Client's understanding of appropriate sexual behavior is *regularly* good.
1 = Possible/Limited Intervention Need	Client's understanding of appropriate sexual behavior is *usually* good *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client's understanding of appropriate sexual behavior is *occasionally* poor.
3 = Strong Intervention Need	Client's understanding of appropriate sexual behavior is *often* poor.

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2. Understanding the Consequences of Sexual Abuse

<u>Definition</u>: Good understanding of the consequences of abusive sexual behavior consists of knowing how all people involved may be affected (e.g., emotionally, physically, legally). Those affected may include the persons who were the focus of the abusive sexual behavior, their family and friends, the client, the client's family and friends, and the larger community. Poor understanding of the consequences of abusive sexual behavior may be reflected by a lack of knowledge of the effects of such behavior.

NOTE:

- Understanding the consequences of abusive sexual behavior does not always translate into engaging in proper and legal behavior. Nonetheless, this item is only concerned with how well the client understands the consequences.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's understanding of the consequences of abusive sexual behavior is *regularly* good.
1 = Possible/Limited Intervention Need	Client's understanding of the consequences of abusive sexual behavior is *usually* good *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client's understanding of the consequences of abusive sexual behavior is *occasionally* poor.
3 = Strong Intervention Need	Client's understanding of the consequences of abusive sexual behavior is *often* poor.

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3. Sexual Thoughts - Frequency

Definition: This item concerns the extent to which the frequency of sexual thoughts is suitable for the person and situation. The frequency of sexual thoughts may be suitable when clients do not experience them as excessively distracting and when they are fitting for a given situation (e.g., when seeing a person whom the client finds sexually attractive). In contrast, the frequency of sexual thoughts is unsuitable when the sexual thoughts preoccupy clients and interfere with important areas of functioning, such as being able to concentrate on a task or assignment.

NOTE:

- When rating this item, it is important to remember that adolescence is a period of heightened sexual interest and arousal.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	The frequency of the client's sexual thoughts is *regularly* suitable.
1 = Possible/Limited Intervention Need	The frequency of the client's sexual thoughts is *usually* suitable *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	The frequency of the client's sexual thoughts is *occasionally* unsuitable and the thoughts preoccupy the client.
3 = Strong Intervention Need	The frequency of the client's sexual thoughts is *often* unsuitable and the thoughts preoccupy the client.

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4. Sexual Interests – Age and Consent

<u>Definition</u>: This item concerns the extent to which clients are sexually interested in consenting sexual activity with age-appropriate partner(s) rather than abusive sexual behavior.

NOTE:

- Prior sexual offenses do not necessarily reflect current or persisting sexual interests in abusive sexual activity.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's sexual interests *regularly* involve consenting sexual activity with age-appropriate partner(s).
1 = Possible/Limited Intervention Need	Client's sexual interests *usually* involve consenting sexual activity with age-appropriate partner(s) *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client's sexual interests *occasionally* involve abusive sexual activities.
3 = Strong Intervention Need	Client's sexual interests *often* involve abusive sexual activities.

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5. Sexual Attitudes and Beliefs

<u>Definition</u>: Prosocial attitudes and beliefs regarding sexual behavior support consenting sexual activity with age-appropriate partner(s). Problematic attitudes and beliefs regarding sexual behavior support abusive sexual behavior.

NOTE:

- This item concerns attitudes and beliefs and cannot be inferred simply from prior offenses or behavior.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's attitudes and beliefs *regularly* support consenting sexual behavior with age-appropriate partner(s).
1 = Possible/Limited Intervention Need	Client's attitudes and beliefs *usually* support consenting sexual behavior with age-appropriate partner(s) *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client's attitudes and beliefs *occasionally* support abusive sexual behavior.
3 = Strong Intervention Need	Client's attitudes and beliefs *often* support abusive sexual behavior.

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6. Sexual Behavior Management

<u>Definition</u>: Appropriate management of sexual behavior involves the extent to which clients behave in safe, legal, and socially appropriate ways. Inappropriately managed sexual behavior may include contact or noncontact offensive, coercive, assaultive and/or otherwise illegal sexual behavior, or sexual behavior that interferes with important areas of functioning (e.g., family or peer relationships, school, or work).

NOTE:

- Incidents involving actual or attempted abusive sexual behavior reflect a moderate (2) or strong (3) intervention need regardless of frequency. The specific rating will depend on factors such as when the incident(s) occurred during the rating period (e.g., early on or recently) and what has happened since (e.g., continued problems or improved behavior management).
- Sexual behavior in a treatment facility that violates agency rules, but would be legal in the community, may be rated as an intervention need if it could lead to further problems for the client (e.g., disciplinary sanctions).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client *regularly* manages sexual behavior appropriately.
1 = Possible/Limited Intervention Need	Client *usually* manages sexual behavior appropriately *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client *occasionally* manages sexual behavior inappropriately.
3 = Strong Intervention Need	Client *often* manages sexual behavior inappropriately.

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7. Compassion for Others

<u>Definition</u>: Compassion concerns the extent to which clients care about and are kind to others, and is demonstrated by supporting and helping others in need. A lack of compassion is evidenced by not caring about others, not supporting or helping others when needed and, at an extreme, by insensitive or callous indifference and/or cruelty to others.

NOTE:

- Minimizing, denying, or rationalizing past offenses does not automatically imply a lack of compassion.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client *regularly* evidences compassion for others.
1 = Possible/Limited Intervention Need	Client *usually* evidences compassion for others *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client *occasionally* evidences a lack of compassion for others.
3 = Strong Intervention Need	Client *often* evidences a lack of compassion for others.

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8. Relationships with Peers

***Definition*: For individuals 17 years or younger, peers are defined as nonfamilial age-mates generally within three years of the client's age. For individuals 18 years and older, peers may include a wider age range. This item concerns the presence, nature, and quality of the client's peer relationships.**

Good peer relationships involve mutually supportive, casual, or close friendships with one or more age-mates whose attitudes and beliefs generally support socially responsible and law-abiding behavior. Poor peer relationships may involve casual or close friendships with one or more age-mates whose attitudes and beliefs generally support irresponsible, rule-violating, or illegal behavior and who may engage in such behavior, and who negatively influence the client. Poor peer relationships also may be indicated by an absence of peer relationships, friendships with individuals who are not peer-aged, and/or by social isolation.

NOTE:

- If the client is currently in a treatment or a correctional facility, positive peer relationships may be observed when clients typically associate with others peers who are engaged in constructive activities (e.g., school, treatment, and prosocial endeavors).
- If peer relationships are primarily limited to online activities, consider the quality and frequency of these contacts.

Current Rating (past 3 months):

0 = No Intervention Need	Client's peer relationships are *regularly* good.
1 = Possible/Limited Intervention Need	Client's peer relationships are *usually* good *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client's peer relationships are *occasionally* poor and/or involve social isolation.
3 = Strong Intervention Need	Client's peer relationships are *often* poor and/or client is socially isolated.

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9. Emotion Management

<u>Definition</u>: Appropriate emotion management is evidenced by clients recognizing their emotions, expressing them properly, and regulating them in ways that are not harmful to self or others (e.g., using stress-management strategies when upset, such as taking time out or seeking support). Inappropriate emotion management may include ignoring feelings, keeping feelings pent up, lashing out at others, or unhealthy attempts to cope with strong emotions (e.g., using alcohol or drugs, having temper outbursts, engaging in destruction of property, or injury to self or others).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client *regularly* manages emotions appropriately.
1 = Possible/Limited Intervention Need	Client *usually* manages emotions appropriately *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client *occasionally* manages emotions inappropriately.
3 = Strong Intervention Need	Client *often* manages emotions inappropriately.

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10. Social Skills

<u>Definition</u>: Good social skills include such things as listening to others, understanding nonverbal social cues, taking turns when talking, maintaining proper personal space, and responding appropriately. Poor social skills include such things as not listening, difficulties understanding nonverbal social cues, interrupting or talking over others, violating personal space, and not responding appropriately.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's social skills are *regularly* good.
1 = Possible/Limited Intervention Need	Client's social skills are *usually* good *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client's social skills are *occasionally* poor.
3 = Strong Intervention Need	Client's social skills are *often* poor.

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11. Self-Confidence

<u>Definition</u>: Good self-confidence is indicated by the extent to which clients believe in their ability to effect and maintain positive life changes for themselves. Poor self-confidence may be indicated by the extent to which clients doubt their ability to be successful or to effect and maintain positive changes. Importantly, poor self-confidence can also be indicated by clients having excessive confidence in their abilities to make and maintain positive life changes in spite of the absence of skills or other supporting evidence congruent with their unwarranted belief.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client *regularly* evidences good self-confidence.
1 = Possible/Limited Intervention Need	Client *usually* evidences good self-confidence *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client *occasionally* evidences poor self-confidence.
3 = Strong Intervention Need	Client *often* evidences poor self-confidence.

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12. School and Work Commitment

<u>Definition</u>: Commitment to school and/or work is indicated by clients generally doing the best that they can in school and/or in the workplace. Commitment may be exampled by appropriate effort, sincere attempts to complete assignments, and regular attendance. Lack of commitment may be indicated by clients generally demonstrating poor effort and motivation, truancy, absenteeism, and/or behavior problems.

NOTE:

- If the client is presently on a school break and is not of employment age, use the last 3-month period when attending school.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's commitment to school and/or work is *regularly* apparent.
1 = Possible/Limited Intervention Need	Client's commitment to school and/or work is *usually* apparent *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client's lack of commitment to school and/or work is *occasionally* apparent.
3 = Strong Intervention Need	Client's lack of commitment to school and/or work is *often* apparent.

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13. Use of Unstructured Time

Definition*: *Unstructured time occurs when clients are not required to engage in prescribed activities, such as school, work, household chores, family gatherings, or during unscheduled time in residential facilities.

Unstructured time that is used well involves engaging in activities that promote positive relationships and/or provide opportunities for healthy outlets. Unstructured time that is used poorly includes spending an inordinate amount of time engaged in solitary activities and/or engaging in rule-breaking or otherwise illegal behavior.

Current Rating (past 3 months):

0 = No Intervention Need	Client *regularly* uses unstructured time well.
1 = Possible/Limited Intervention Need	Client *usually* uses unstructured time well *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client *occasionally* uses unstructured time poorly.
3 = Strong Intervention Need	Client *often* uses unstructured time poorly.

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14. Nonsexual Behavior Attitudes and Beliefs

<u>Definition</u>: Prosocial attitudes and beliefs regarding nonsexual behavior support socially appropriate, rule-abiding, and/or legal, nonsexual behavior. Problematic attitudes and beliefs regarding nonsexual behavior support socially inappropriate, rule-violating, and/or illegal nonsexual behavior.

NOTE:

- This item concerns attitudes and beliefs and cannot be inferred simply from prior offenses or behavior.
- Attitudes and beliefs regarding sexual behavior are rated on Item 5 (Sexual Attitudes and Beliefs).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's attitudes and beliefs *regularly* support socially appropriate and law-abiding nonsexual behavior.
1 = Possible/Limited Intervention Need	Client's attitudes and beliefs *usually* support socially appropriate and law-abiding nonsexual behavior *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client's attitudes and beliefs *occasionally* support socially inappropriate, rule-violating, and/or illegal nonsexual behavior.
3 = Strong Intervention Need	Client's attitudes and beliefs *often* support socially inappropriate, rule-violating, and/or illegal nonsexual behavior.

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15. Nonsexual Behavior Management

<u>Definition</u>: Appropriate management of nonsexual behavior involves the extent to which clients behave in safe, legal, and socially appropriate ways. Inappropriately managed nonsexual behavior may include contact or noncontact offensive, coercive, aggressive, and otherwise illegal behaviors that interfere with important areas of functioning (e.g., family or peer relationships, school or work).

NOTE:

- Violent or assaultive incidents that risked or caused injury to self, others, or property reflect a moderate (2) or strong (3) intervention need regardless of frequency. The specific rating will depend on factors such as when the incident(s) occurred during the rating period (e.g., early on or recently) and what has happened since (e.g., continued problems or improved behavior management).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client *regularly* manages nonsexual behavior appropriately.
1 = Possible/Limited Intervention Need	Client *usually* manages nonsexual behavior appropriately *with no more than a few minor exceptions <u>not</u> involving violent or assaultive behavior*.
2 = Moderate Intervention Need	Client *occasionally* manages nonsexual behavior inappropriately.
3 = Strong Intervention Need	Client *often* manages nonsexual behavior inappropriately.

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16. Client View of Primary Caregiver Relationship

<u>Definition</u>: A Primary Caregiver is a person in a parenting role who is viewed by clients as most influential in their life during the current rating period. Clients experiencing a positive relationship with a Primary Caregiver typically describe the relationship as caring, helpful, and supportive. Clients experiencing a negative relationship with a Primary Caregiver usually describe the relationship as uncaring, unhelpful, and unsupportive; possibly rejecting, neglectful, and/or abusive.

NOTE:

- This item assesses the client's view of the relationship.
- When there are multiple caregivers involved in the client's life, rate this item based on the caregiver the client identifies as <u>currently</u> most influential.
- If the client is living independently as an adult and no longer has a Primary Caregiver, rate as No Intervention Need (0).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client indicates *regularly* having a positive relationship with a Primary Caregiver.
1 = Possible/Limited Intervention Need	Client indicates *usually* having a positive relationship with a Primary Caregiver *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client indicates *occasionally* having a negative relationship with a Primary Caregiver.
3 = Strong Intervention Need	Client indicates *often* having a negative relationship with a Primary Caregiver.

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17. Client View of Supportive Adult Relationships

<u>Definition</u>: This item concerns how clients view their relationships with one or more supportive adults during the current rating period. It does not include the Primary Caregiver relationship rated in Item 16. Supportive adults with whom clients have positive relationships are experienced as providing genuine interest, guidance, and positive encouragement. In contrast, clients may lack even one such supportive, positive relationship, or they may only experience relationships with adults who provide little interest, guidance, or positive encouragement.

NOTE:

- For clients 18 years and older, this item does not include peer relationships rated on Item 8, but adults who may serve more as a guide, support, or mentor rather than as a peer.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client indicates *regularly* having a positive relationship with one or more supportive adults.
1 = Possible/Limited Intervention Need	Client indicates *usually* having a positive relationship with one or more supportive adults *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Client indicates *occasionally* lacking a positive relationship with any supportive adult.
3 = Strong Intervention Need	Client indicates *often* lacking a positive relationship with any supportive adults.

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18. Family Functioning

<u>Definition</u>: Families include persons considered to be members of a client's primary social unit either by birth, adoption, fostering, or marriage. As such, family members may include parents or substitute caregivers, siblings or other children cared for by the client's caregivers, and/or extended family members living in the home. In cases involving young adult clients, family units may include adult partners or spouses.

Good family functioning may involve family members providing clients with emotional support, encouragement, guidance, and participation in suggested interventions. By contrast, poor family functioning may involve a lack of such support and, at an extreme, rejecting, hostile, or otherwise abusive behavior toward clients. In addition, troublesome family relationships that contribute to poor family functioning may involve situations when a family member has been abused by a client and relationships remain strained.

NOTE:

- Although relationships with individual family members may vary, ratings of this item are based on overall family functioning.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Family functioning is *regularly* good.
1 = Possible/Limited Intervention Need	Family functioning is *usually* good *with no more than a few minor exceptions*.
2 = Moderate Intervention Need	Family functioning is *occasionally* poor.
3 = Strong Intervention Need	Family functioning is *often* poor.

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19. Living Situation - Safety and Stability

<u>Definition</u>: Safety and stability in the living situation concerns the extent to which the family home or alternative residence provides a safe, consistent, and stable environment that is generally free from severe and chronic stressors. Unsafe and unstable living situations include the presence of significant stressors such as exposure to or experiencing violence, neglect of basic needs, frequent changes in household members, living with people engaging in substance abuse or with uncontrolled mental health problems, and/or not providing the client with adequate supervision when expected to do so.

***NOTE*:**

- When the client has changed residences during the past 3 months, consider the safety and stability of the current living situation.
- If a change in the client's living situation is imminent, consider the safety and stability of the planned residence.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Safe and stable living conditions are *regularly* experienced.
1 = Possible/Limited Intervention Need	Safe and stable living conditions are *usually* experienced with *no more than a few minor exceptions.*
2 = Moderate Intervention Need	Unsafe and/or unstable living conditions are *occasionally* experienced.
3 = Strong Intervention Need	Unsafe and/or unstable living conditions are *often* experienced.

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20. Involvement in Community Resources

<u>Definition</u>: Involvement in community resources concerns clients' (and sometimes their families') engagement in available community services and supports that may promote the health and safety of clients returning to and/or living in the community (e.g., housing assistance, job training programs, tutoring, after school activities). A lack of involvement may be indicated by minimal or no engagement in available supports that may promote healthy and safe living.

NOTE:

- Rate as a No Intervention Need (0) if community resources are not needed at this time.
- If the client is currently in a residential facility, rate based on the client's access to community and/or community resources that are available while in residence (e.g., community-based mentors who visit in the facility).
- If the client, or client and family, would benefit from community resources that are unavailable, rate this item to reflect client need and seek or refer for services that may help meet this need.

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client is *regularly* involved with community resources or community resources are not needed at this time.
1 = Possible/Limited Intervention Need	Client is *usually* involved with community resources *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client *occasionally* lacks involvement with community resources.
3 = Strong Intervention Need	Client *often* lacks involvement with community resources.

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21. Mental Health Management

<u>Definition</u>: Mental health concerns may interfere with engagement and participation in interventions. Good management may be indicated by no symptoms, or relatively few symptoms, of mental health concerns and/or active participation in recommended mental health services. Poor management may be indicated by symptoms of mental health concerns interfering with active participation in interventions.

NOTE:

- When clients do not have mental health concerns that interfere with interventions, rate as No Intervention Need (0).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client's mental health concerns are *regularly* well-managed or client does not have mental health concerns.
1 = Possible/Limited Intervention Need	Client's mental health concerns are *usually* well-managed *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client's mental health concerns are *occasionally* managed poorly.
3 = Strong Intervention Need	Client's mental health concerns are *often* managed poorly.

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22. Participation in Interventions

<u>Definition</u>: Good participation in relevant, offense-related interventions (e.g., sex offense and/or delinquency treatments, juvenile or adult probation, community service) is demonstrated by such things as regular attendance, active involvement in sessions, completing assignments, and generalizing new learning (e.g., using what is learned in various situations). Poor participation may be demonstrated by such things as lateness, irregular attendance, a lack of involvement in sessions, not completing assignments, and/or a lack of generalization of new learning.

NOTE:

- When offense-related interventions are not needed, rate as No Intervention Need (0).

<u>Current Rating (past 3 months):</u>

0 = No Intervention Need	Client participation in interventions is *regularly* good or offense-related interventions are not needed.
1 = Possible/Limited Intervention Need	Client participation in interventions is *usually* good *with no more than a few minor exceptions.*
2 = Moderate Intervention Need	Client participation in interventions is *occasionally* poor.
3 = Strong Intervention Need	Client participation in interventions is *often* poor.

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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): _____

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Youth Needs and Progress Scale: Progress Over Time - Rating Form

Name: _____ ID # _____ Age: _____

Type of assessment:	Initial assessment	Re-assessment T1	Re-assessment T2	Re-assessment T3	Re-assessment T4
Assessment Date:					
1. **Understanding Appropriate Sexual Behavior**					
2. **Understanding the Consequences of Sexual Abuse**					
3. **Sexual Thoughts - Frequency**					
4. **Sexual Interests - Age & Consent**					
5. **Sexual Attitudes & Beliefs**					
6. **Sexual Behavior Management**					
7. **Compassion for Others**					
8. **Relationships with Peers**					
9. **Emotion Management**					
10. **Social Skills**					
11. **Self-confidence**					
12. **School & Work Commitment**					
13. **Use of Unstructured Time**					
14. **Nonsexual Behavior Attitudes and Beliefs**					
15. **Nonsexual Behavior Management**					
16. **Client View of Primary Caregiver Relationship**					
17. **Client View of Supportive Adult Relationships**					
18. **Family Functioning**					
19. **Living Situation - Safety & Stability**					
20. **Involvement in Community Resources**					
21. **Mental Health Management**					
22. **Participation in Interventions**					

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Youth Needs and Progress Scale: Proportion of Needs - Summary

- **Proportion of no or possible/limited needs versus clear intervention needs:**

To calculate the extent to which the client has no or limited intervention needs, add the number of ratings endorsed in the categories No and Possible/Limited Intervention Need [0, 1] and divide the total by the number of scale items rated as a 0, 1, 2, or 3, i.e., all 22 items if every scale item is rated and no items had insufficient information for a rating (endorsed as "unable to rate" on the Rating Form). Similarly, to calculate the extent to which Moderate and Strong Intervention Needs [2, 3] are present, divide the total number of items tallied in these two categories by the total number.

- **Proportion of No or Possible/Limited Intervention Needs _____%**

  [Number of items rated 0 or 1 / Total number of items rated]

- **Proportion of Moderate or Strong Intervention Needs _____%**

  [Number of items rated 2 or 3 / Total number of items rated]

- **Proportion of items unable to rate (insufficient information)**

To determine the extent to which further information is needed to adequately rate this scale, tally the number of items endorsed as "unable to rate" and divide by the total number of items in the scale (22).

- **Proportion of items checked "unable to rate" _____%**

  [Number of items rated "unable to rate" / 22 Scale Items]

- **Proportion of intervention need by strength:**

To calculate the extent to which possible or actual intervention needs are present add the number of ratings endorsed [possible range: 0-22] per category [0, 1, 2, 3]. Divide the total number of items tallied in each category by the total number of scale items rated in each category, i.e., all 22 items if every scale item is rated and no items had insufficient information for a rating (endorsed as "unable to rate" on the Rating Form).

- **Proportion of ratings of 0; No Intervention Needs _____%**

  [Number of items rated 0 / Total number of items rated]

- **Proportion of ratings of 1; Possible/Limited Intervention Needs _____%**

  [Number of items rated 1 / Total number of items rated]

- **Proportion of ratings of 2; Moderate Intervention Needs _____%**

  [Number of items rated 2 / Total number of items rated]

- **Proportion of ratings of 3; Strong Intervention Needs _____%**

  [Number of items rated 3 / Total number of items rated]

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Youth Needs and Progress Scale: Proportion of Needs Over Time - Summary

Name: _____ ID # _____ Age: _____

Assessment type:	Initial Assessment	Re-Assessment T1	Re-Assessment T2	Re-Assessment T3	Re-Assessment T4
Assessment Date:					
Proportion No or Possible/Limited Intervention Needs					
Proportion Moderate or Strong Intervention Needs					
Proportion of items checked "unable to rate"					
Proportion of ratings of 0; No Intervention Needs					
Proportion of ratings of 1; Possible/Limited Intervention Needs					
Proportion of ratings of 2; Moderate Intervention Needs					
Proportion of ratings of 3; Strong Intervention Needs					

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Appendix D: Data Codebook

Codebook REDCap Data Set—DOJ TNPS Project

Updated 31 December 2019

Table of Contents

***"R" after variable name = recoded variable*

dIDdup = De-identifier with duplicates for the repeated assessments
dIDu = Unique numeric de-ID

PART I: General Information: Intro to Historical Items

1) Assessmt (Order of TNPS assessments)
   - 0 0. Initial TNPS assessment & historical items
   - 1 1. 1st TNPS reassessment
   - 2 2. 2nd TNPS reassessment
   - 3 3. 3rd TNPS reassessment
   - 4 4. 4th TNPS reassessment
   - 5 5. 5th TNPS reassessment
   - 6 6. 6th TNPS reassessment
   - 7 7. 7th TNPS reassessment
   - 8 8. 8th TNPS assessment

2) I1Carelevel (I1. Level of care at the time of the intake assessment)
   - 0 0. Community
   - 1 1. Secure facility

3) I2evaldatei (I2. Date of historical items assessment)
   Actual date xx/xx/xxx

4) I3ageyri (Age in years at initial historical items assessment)
   Actual age xx

5) I3ageyriR (Age categorized into 2 groups)
   (original version is a continuous variable)
   - 0 0. age 14-17
   - 1 1. age >18

6) I4newjso (Was the youth in treatment prior to TNPS assessment)
   - 0 0. No
   - 1 1. Yes

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7) Sex

0	0. Male
1	1. Female

8) Race / Ethnicity

1	1. African American / Black
2	2. Asian
3	3. Hispanic / Latino
4	4. Native American
5	5. Other
5	6. European American / White

PART II: Historical Items

1) h1npsb (h1 ORIGINAL: Number of problematic sexual behavior (PSB) incidents)
   - 0 0. 1 instance
   - 1 1. 2-3 instances
   - 2 2. 3-5 instances
   - 3 3. 6 or more instances

2) h1npsbR (h1 RECODED: Number of instances of abusive sexual behavior with condensed categorization)
   - 0 0. None
   - 1 1. One to two
   - 2 2. 3 or more

3) h2nsav (h2 ORIGINAL: Number of sexual abuse victims)
   - 0 0. 1 known victim
   - 1 1. 2 known victims
   - 2 2. 3-5 known victims
   - 3 3. 6 or more known victims

4) h2nsavR (h2 RECODED: Number of sexual abuse victims with condensed categorization)
   - 0 0. 1 known victim
   - 1 1. 2-3 known victims
   - 2 2. 2 or more known victims

5) h6nncon (h6 ORIGINAL: Number of non-contact offenses)
   Actual number xx

6) h6nnconR (h6 RECODED: Number of non-contact offenses—original version is a continuous variable)
   - 0 0. None
   - 1 1. 1-2
   - 2 2. 3 or more

7) h7naiicon (h7 ORIGINAL: Continuous variable)
   Actual number xx

8) h7naiiconR (h7 RECODED: Number of credible contact (hands-on) abusive sexual behavior)
   - 0 0. None
   - 1 1. 1-2
   - 2 2. 3 or more

9) h8nchcon (h8 ORIGINAL: Number of charged contact (hands on) offenses—continuous variable)
   Actual number xx

10) h8nchconR (h8 RECODED: Number of charged contact (hands on) offenses)
   (original version is a continuous variable)
   - 0 0. None
   - 1 1. 1-2
   - 2 2. 3 or more

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11) h9peerv (h9: All victims are peers and/or adults)
- 0 0. No
- 1 1. Yes

12) h10mixagev (h10: Mixed aged victims)
- 0 0. No
- 1 1. Yes

13) h12anchildv (h12a. # of boy victims under age 12)
Actual number xx

14) h12bnumgirls (h12b. # of girl victims under age 12)
Actual number xx

15) h12childmixR (RECODED items 9, 10, 11, and 12 a & b into categorical 'Type of victims')
- 1 1. Only under age 12 victims (counts if age 14 or >)
- 2 2. Mixed aged victims
- 3 3. Only peer & adult victims

16) h13cd (h13 ORIGINAL: Conduct problems prior to age 10)
- 0 No evidence of any conduct or behavioral problems routinely. Evidence of sharing, helping or cooperating…
- 1 No evidence of any conduct or behavioral problems most of the time. Evidence of sharing, helping or…
- 2 Evidence of disruptive and / or aggressive behaviors that exceed what would be considered acceptable…
- 3 Evidence of varied disruptive behavior problems often, such as bullying, hitting, biting, kicking, lying…
- 4 Not enough information to rate. (* recoded 4 = missing)

17) h13cdR (h13 RECODED: Conduct problems prior to age 10 dichotomized)
- 0 0. None to minor
- 1 1. Major to severe

18) h14jd (h14 ORIGINAL: Juvenile delinquent behavioral problems)
- 0 No evidence of any delinquent or antisocial behavioral problems routinely. All friends and activities…
- 1 No evidence of any delinquent, aggressive, or intentionally hurtful or disruptive behaviors most of the time…
- 2 Evidence of disruptive, antisocial behaviors occasionally. If in a group, delinquent behaviors are started…
- 3 Evidence of a pattern of disruptive and antisocial behaviors characterized by both overt and covert hostility…
- 4 Not enough information to rate. (* recoded 4 = missing)

19) h14jdR (h14 RECODED: Juvenile delinquent behavior problems dichotomized)
- 0 0. None to minor
- 1 1. Major to severe

Item #15: Check all that apply—Charged Delinquent / Criminal Behavior

Same rating system for all items below

20) h15chdeliq1 (Sex offense only)

0	0. No
1	1. Yes

21) h15chdeliq2 (Violent: persons involved, assault, fighting)

0	0. No
1	1. Yes

22) h15chdeliq3 (Property: theft, larceny, robbery, burglary)

0	0. No
1	1. Yes

23) h15chdeliq4 (Property: destruction)

0	0. No
1	1. Yes

24) h15chdeliq5 (Fraud)

0	0. No
1	1. Yes

25) h15chdeliq6 (Serious drug offense)

0	0. No
1	1. Yes

26) h15chdeliq7 (Serious motor vehicle)

0	0. No
1	1. Yes

27) h15chdeliq8 (Conduct offenses: disorderly conduct, probation violation)

0	0. No
1	1. Yes

28) h15chdeliq9 (Cyber / Internet)

0	0. No
1	1. Yes

29) h15chdeliq10 (Status offenses: runaway, truancy)

0	0. No
1	1. Yes

Item #16 (h16)

Same rating system for all items below

30) h16agesa (h16a ORIGINAL: Age of 1st sexual abuse; ORIGINAL)

1	1. N/A No Abuse
2	2. Insufficient information / unclear
3	3. Witnessed abuse only (saw or heard)
4	4. Age < 6
5	5. Age 6-11
6	6. Age 12-14
7	7. Age 15-18

31) h16agepa (h16b ORIGINAL: Age of 1st physical abuse)

1	1. N/A No Abuse
2	2. Insufficient information / unclear
3	3. Witnessed abuse only (saw or heard)
4	4. Age < 6
5	5. Age 6-11
6	6. Age 12-14
7	7. Age 15-18

32) h16ageea (h16c ORIGINAL: Age of 1st psychological abuse)

1	1. N/A No Abuse
2	2. Insufficient information / unclear
3	3. Witnessed abuse only (saw or heard)
4	4. Age < 6
5	5. Age 6-11
6	6. Age 12-14
7	7. Age 15-18

33) h16ageneg (h16d ORIGINAL: Age of 1st neglect)

1	1. N/A No Abuse
2	2. Insufficient information / unclear
3	3. Witnessed abuse only (saw or heard)
4	4. Age < 6
5	5. Age 6-11
6	6. Age 12-14
7	7. Age 15-18

34) h16agesaR (h16a RECODED: Sexual abuse dichotomized yes / no)

0	0. No abuse
1	1. Abused

35) h17sevsa (h17a ORIGINAL: Severity of sexual abuse)

1	1. Insufficient information / unclear
2	2. Minimal
3	3. Moderate
4	4. Severe

36) h17sevpa (h17b ORIGINAL: Severity of physical abuse)

1	1. Insufficient information / unclear
2	2. Minimal
3	3. Moderate
4	4. Severe

37) h17sevea (h17c ORIGINAL: Severity of psychological abuse)

1	1. Insufficient information / unclear
2	2. Minimal
3	3. Moderate
4	4. Severe

38) h17sevneg (h17d ORIGINAL: Severity of neglect)

1	1. Insufficient information / unclear
2	2. Minimal
3	3. Moderate
4	4. Severe

39) h17sevsaR (h17a RECODED: Severity of sexual abuse dichotomized)

0	0. Minimal
1	1. Moderate or severe

40) h18pi (h18 ORIGINAL: Placement instability)

1	1. N/A No Changes
2	2. Insufficient information / unclear
3	1. Minimal 1
4	4. Moderate 2-3
5	5. Considerable 4-5
6	6. Extensive >5

41) h18piR (h18 RECODED INTO 2 CATEGORIES: Placement instability with condensed categorization)

0	0. No changes or minimal
1	1. Moderate, considerable, OR extensive

42) h18piR (h18 RECODED INTO 4 CATEGORIES: Placement instability with condensed categorization)

0	0. No changes
1	1. Minimal
2	2. Moderate
3	3. Considerable & extensive

General Information:
Treatment Needs & Progress Scale Intro Items

1) A1carelevel2 (A1. Level of care at assessment)
   - 0 0. Supervised in community
   - 1 1. In a secure facility

2) A2evaldater
   Actual date xx/xx/xxx

3) A3ageyr
   Actual age xx

4) A4intakecomplete2 (Was the assessment the initial intake assessment, a reassessment, or a discharge assessment?)
   - 1 1. Initial Treatment Needs & Progress Scale Assessment
   - 2 2. Reassessment of Treatment Needs & Progress
   - 3 3. Discharge assessment of Treatment Needs & Progress

5) A5Txstatus (ORIGINAL A5: Treatment status)
   - 1 1. Active
   - 2 2. Refused
   - 3 3. Removed
   - 4 4. Dropped out
   - 5 5. Completed
   - 6 6. N/A, not applicable

6) A5txstatusR (A5 RECODED: Treatment status dichotomized)
   - 0 0. Completed or active
   - 1 1. Refused, dropped out, kicked out, etc.

CHECK ALL THAT APPLY
Same rating system for all items below

1) A6Indivdtherapy (Individual therapy)
   - 0 0. No
   - 1 1. Yes

2) A7Familytherapy (Family therapy)
   - 0 0. No
   - 1 1. Yes

3) A8Grouptherapy (Group therapy)
   - 0 0. No
   - 1 1. Yes

4) A9Othertherapy (Other therapy)
   - 0 0. No
   - 1 1. Yes

Treatment Needs & Progress Scale (TNPS; 27 Dynamic Items)

(all N/A & not enough info is coded as missing for the 27 items below)

Same rating system for all TNPS dynamic items below

0	0. No Treatment Need
1	1. Possible/Limited Treatment Need
2	2. Moderate Treatment Need
3	3. Strong Treatment Need

1) d1 (Frequency of sexual thoughts)
2) d2 (Sexual interests)
3) d3 (Sexual self-management)
4) d4 (Understanding appropriate sexual behavior)
5) d5 (Understanding the consequences of abuse sexual behavior)
6) d6 (Sexual attitudes & beliefs)
7) d7 (Behavioral self-management)
8) d8 (School / Work)
9) d9 (Free time)
10) d10 (Lawful behavior)
11) d11 (Attitudes & beliefs supporting nonsexual illegal behavior)
12) d12 (Peer-aged friendships)
13) d13 (Peer associations)
14) d14 (Relationship with primary caregiver (client's perspective)
15) d15 (Adult mentors)
16) d16 (Social skills)
17) d17 (Problem-solving)
18) d18 (Emotional management)
19) d19 (Self-efficacy)
20) d20 (Compassion)
21) d21 (Difficulties due to sexual abuse
22) d22 (Difficulties due to negative nonsexual life experiences)
23) d23 (Attitudes toward interventions)
24) d24 (Management of co-occurring psychological & behavioral health symptoms)
25) d25 (Supportive primary caregiver or significant other)
26) d26 (Stability in living situation)
27) d27 (Community Support)

Appendix E: The Natural Development of Adolescents

The Natural Development of Adolescents

Research on Bio-physical & Cognitive Development in Adolescence

Aristotle quipped, over 2,300 years ago, that "Youth are heated by nature as drunken men by wine." And Shakespeare added, almost 400 years ago in The Winter's Tale (Act III), "I would that there were no age between 10 and 23, for there's nothing in between but getting wenches with child, wrongdoing the ancientry, stealing, fighting …" Only recently, however, have these sage observations been supported by a wealth of empirical data demonstrating that adolescence is indeed a time of extraordinary maturational change in virtually all domains of development, from physical and biological to emotional, cognitive, neuro-cognitive, social, sexual, and behavioral (e.g., Albert & Steinberg, 2011; Bonnie & Scott, 2013; Borum & Verhaagen, 2006; Casey, Getz, & Galvan, 2008; Cauffman & Steinberg, 2000; Cohen et al., 2016; Cohen & Casey, 2014; Dahl, 2001, 2003, 2004; Iselin, DeCoster, & Salekin, 2009; Luna & Wright, 2016; Modecki, 2008; Owen-Kostelnik, Reppucci, & Meyer, 2006; Reyna & Farley, 2006; Spear, 2000; Steinberg, 2004, 2007, 2009; Steinberg & Cauffman, 1996; Steinberg & Scott, 2003; van den Bos, van Dijk, Westenberg, Rombouts, & Crone, 2011). The New York Academy of Sciences devoted a 2003 conference entirely to the topic of Adolescent Brain Development (Dahl & Spear, 2004). An entire Special Issue of *Current Directions in Psychological Science* (2013) was devoted to the "teenage brain," featuring fourteen articles. Risk-taking, sensation-seeking, impulsivity, poor decision-making, illegal behaviors, and intense, unstable emotions are all *normative* in adolescence, not something idiosyncratic to delinquent youth. It is clear that even the adolescent central nervous system is developing (e.g., Giedd, 2004; Luna & Sweeney, 2004), and that structural development corresponds with psychological growth.

A particular relevance to a focus on "the teenage brain" is the timeframe for maturity of the prefrontal cortex (PFC), extending into the mid-twenties, in some cases age 25 (Dahl & Spear, 2004). The PFC is critically important in controlling impulsive decision-making. For example, Cohen and her colleagues (2016) found "a developmental shift in cognitive control in negative emotional situations during young adulthood that is paralleled by dynamic developmental changes in prefrontal circuitry" (p. 11). Bostic, Thurau, Potter, and Drury (2014) similarly noted that adolescents tend to process information less through the prefrontal cortex than adults, and more through the amygdala, particularly during highly emotional situations, and that this can lead to more erratic behaviors.

In addition to structurally-based neurological developments, neurobehavioral changes in adolescence have been linked to puberty (Dahl, 2004). For example, marked changes have been observed in both the reproductive and stress hormones associated with maturational changes in several domains, including: sexual arousal, emotional intensity and lability, sleep, appetite, and risk taking behaviors. As Steinberg (2004) pointed out, the hedonic motive during this period of development "overshadows rational recognition of adverse outcomes" and "is normative, biologically driven and inevitable," (pg. 57). Steinberg (2007) subsequently remarked that adolescence is a period of increased vulnerability for high-risk behaviors and impulsivity, due in part to the difference in timing of puberty onset (i.e., which leads to sensation seeking) and the development of the cognitive-control system (i.e., which aids in impulse control). These problems are only magnified by the hormonal paroxysm brought on by puberty (Beaver & Wright, 2005).

The science of juvenile developmental immaturity and flux now serves as the empirical foundation for three important Supreme Court decisions. In the Brief submitted by the American

Psychological Association and the Missouri Psychological Association (Brief, 2004) in *Roper v. Simmons* (2005), the authors remarked that juveniles are "moving targets" with regard to dangerousness risk and character assessment, as "the transitory nature of adolescence also means that an adolescent defendant is much more likely to change in relevant respects between the time of the offense and the time of assessment by courts and experts" (p. 3). In a landmark decision, SCOTUS held in *Roper* that it is unconstitutional to impose capital punishment for crimes committed while under the age of 18. In *Graham v. Florida* (2010), SCOTUS held that juvenile offenders cannot be sentenced to life imprisonment without parole for non-homicide offenses. *Miller v. Alabama* (2012) held that *mandatory* sentences of life without the possibility of parole (LWOP) are unconstitutional for juvenile offenders. In applying to those persons who had committed murder as a juvenile, *Miller* extended *Graham,* which had ruled LWOP sentences were unconstitutional for crimes *excluding murder*. Writing for the majority in *Miller,* Justice Elena Kagan wrote "that mandatory life without parole for those under age of 18 at the time of their crime violates the 8th Amendment's prohibition on cruel and unusual punishments", noting "Mandatory life without parole for a juvenile precludes consideration of his chronological age and its hallmark features – among them, immaturity, impetuosity, and failure to appreciate risks and consequences."

Overall, adolescence is characterized, even under the best of conditions, by markedly impaired decision-making, as rational decisions give way to intense emotions and a notable incidence of risk-taking. In addition, however, there is a complex social chemistry in which peers become powerful influences on behavior, again hormonally augmented with the onset of puberty. In other words, adolescence is a developmental twilight zone between childhood and adulthood that is often characterized by radical emotional changes in response to hormonal shifts, high-

intensity feelings, emotionally-charged, impulsive, risky behaviors, and poor decision-making (Kelley, Schochet & Landry, 2004). What occurs under "normal" conditions may be further complicated by exposure to distinctly suboptimal conditions of neglect, abuse and patently inadequate, inappropriate or, worse, harmful interventions. These "suboptimal" conditions often occur *real time* (roughly the same time-frame as the assessment). Family circumstances, home environment, placements, caregivers, school, peers and other life situations of adolescents may change rapidly or within a short time-frame. Hence, the social ecology of youth may increase risk or be protective (Henggeler, Letourneau, Chapman, Borduin, Schewe, & McCart, 2009). In sum, the risk "temperature" of adolescents is arguably much more variable and unstable than that of adults. Although capturing this variability is a significant methodological challenge, it is essential for improving the accuracy of our assessments, as well as improving our management decisions. These "suboptimal" conditions are potentially highly "destabilizing" from the standpoint of assessment, precipitating reactive but otherwise short-lived behavioral responses to situational or environmental catalysts. Moreover, when these "conditions" include severe, protracted abuse, the abuse may lead to invisible, hard-wired brain damage that contribute to longer-term deficits and behavioral challenges (e.g., DeBellis, Baum, Birmaher et al. 1999; DeBellis, Keshavan, Clark, Casey, Giedd, Boring, Frustaci, & Ryan, 1999; Ferris, 1996; Ito, Teicher, Glod, Harper, Magnus, & Gelbard, 1993; Ito, Teicher, Glod, & Ackerman, 1998; Perry, 1994; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Stein, 1997; Stien & Kendall, 2004; Teicher, 2000, 2002; Teicher, Glod, Andersen, Dumont, & Ackerman, 1997; Teicher, Glod, Surrey, & Swett, 1993; Thomas & Johnson, 2008).