

**A Collaborative Approach For Family Reconciliation And Reunification
With Youth Who Have Caused Sexual Harm**
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Introduction

The field of treating sexual harm by juveniles is rife with contradiction. While the Association for the Treatment of Sexual Abusers (ATSA) acknowledges that most adolescents who have committed sexual crimes can be safely managed in communities through collaboration among juvenile justice, parents, or guardians, and other pertinent supports (ATSA, 2000), residential placements for these youth skyrocketed (Burton & Smith-Darden, 2001; Puzzanchera, 2000) during the last decade of the 20th century. Current trends indicate a reduction in residential placement for youth who have caused sexual harm, but a significant number continue to be placed away from home.

Sensational media coverage of sex offenders and adolescent registry requirements would have society believing that all of these youth are sexually violent predators and pedophiles who should be shunned for the rest of their lives. Recidivism rates do not support such a response. In fact, a number of studies indicate low rates of sexual re-offense among populations of youth who have sexually abused (Alexander, 1999; Schram, Milloy, & Rowe, 1991; Worling & Curwen, 2000). Not all youth adjudicated for sexual crimes pose a risk to community safety and require offense specific residential treatment.

Youth who have completed offense-specific treatment have the potential to return successfully to their home communities. Since recidivism rates indicate a higher risk of non-sexual criminal behavior (Langstrom & Grann, 2000; Schram, Milloy, & Rowe, 1991; Worling & Curwen, 2000) it is imperative that reconciliation and reunification efforts incorporate a holistic approach that promotes safety in all aspects of each youth's life.

The Office of the Surgeon General (2001) has identified residential treatment as an ineffective practice for youth violence prevention , and there is little evidence-based practice to guide intervention in out-of-home placement. There are no documented evidence-based or promising practices for transitioning youth who have caused sexual harm out of residential placement. The lack of valid and reliable scales for assessing risk at the end of treatment prevents actuarial prediction. Agencies intent on providing ethical and responsible services are in a quandary about what to do and have little research for guidance (Hunter & Chaffin, 2005). This chapter attempts to integrate evidence relating to youth violence prevention, optimum child development, and resilience into a protocol for transition planning and implementation to enhance long-term harm reduction. It uses restorative justice (Zander & Zander, 2000; Zehr, 2002) as a philosophical foundation.

Complexities inherent in family reconciliation and reunification with youth who have caused sexual harm require thoughtful attention. Professionals must address a wide array of issues in order to ensure continuous treatment and transition planning, monitoring, and supervision. The chapter begins with definitions and a conceptual framework for reconciliation and reunification. After describing a range of challenges that service providers face when implementing reconciliation and reunification, a framework of restorative justice (Zehr, 2002) will illuminate the vision, mission, and core values that can guide the process. Concepts from Motivational Interviewing (Miller & Rollnick, 2002) will highlight a therapeutic process. Case scenarios will highlight a range of concerns. Finally, the foundation of this chapter is that reconciliation and reunification can proceed only after a youth has apologized and actively made amends to everyone impacted by the sexually harmful behavior.

Reconciliation and Reunification

According to *Webster's New World Dictionary* (Guralnik, 1986) reconcile means "to make friendly again; to settle; bring into harmony." Family reconciliation is the process of supporting families in this effort when their child has behaved in sexually harmful ways. It is a process of healing emotional wounds caused by harmful behavior.

The same source (Guralnik, 1986) defines reunification as "to unify again after being divided." For the purpose of this chapter, "family reunification" represents the physical rejoining of family members with a youth who has been removed from the home. It includes, but is not limited to, the following components:

- assessing youthful harm reduction
- assessing individual, family and community strengths and vulnerabilities
- assessing victim recovery, strengths and vulnerabilities
- recognizing, and monitoring therapeutic change in individuals, and family members
- honoring a family commitment to stop violence and sexual harm
- maintaining elements of optimum child development (National Research Council and Institute of Medicine, 2001) in the home
 1. physical and psychological safety
 2. appropriate structure
 3. supportive relationships
 4. opportunities to belong
 5. positive social norms
 6. support for efficacy and mattering
 7. opportunities for skill building; and
 8. integration of family, school and community efforts
- establishing protocols for immediate response to risk behavior
- planning for success
- monitoring, supervision and surveillance

Vital to reconciliation and reunification is adherence to best practices for youth violence prevention (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002; Office of the Surgeon General, 2001) and a collaborative social support network in order to prevent further harm.

It is extremely important to distinguish between "reconciliation" and "reunification." Family members can receive support in their efforts to reconcile experiences of violence and/or sexual harm without actual reunification. Reunifying a family without reconciliation is potentially fraught with danger and increased risk of recidivism. Successful reconciliation may lead the way to reunification. Barriers to reconciliation impede reunification.

Maintaining therapeutic change after treatment represents the most important function of intervention in youthful sexual aggression. The true test for life-long harm reduction begins upon the youth's release from residential treatment. The transition from residential to community living places extraordinary stress on adolescents who have caused sexual harm and their family members. This experience often involves a return to the same environment where the sexual aggression occurred. A youth may be in contact with people who played a part in the abusive lifestyle and who may be ambivalent about his or her return. Community safety and political and social pressure regarding community notification create challenges for planning community reintegration, family reconciliation and reunification, and aftercare services.

Family reconciliation and reunification require unique processes depending on a variety of issues relating to victims, family dynamics, geography, court orders, and mandates. For example, different protocols are followed depending upon whether a victim is a family member

residing in the home, or there is a court order requiring no victim contact.

Family reconciliation and reunification are often primary goals when collaborating with families to stop youthful violence and sexual harm. There are usually several larger systems involved in making decisions about the youth's situation. These may include personnel from criminal justice, social services, public or private residential treatment programs, community treatment programs, schools and work settings. It is imperative that clinicians involved in this effort understand the importance of facilitating multidisciplinary communication and teamwork. Having protocols to follow in such a challenging process can help to unify multidisciplinary efforts, streamline processes, enhance best practice service provision, and influence successful treatment outcomes.

Treatment providers experience the challenge of exploring successful outcomes while working in settings that demand high caseloads, have limited financial resources for aftercare services, and maintain meager interagency communication and cooperation.

Barriers to Successful Reconciliation and Reunification

Systems of Care

Reconciliation and reunification depend on collaboration among a range of service providers. Most often state departments of social services and/or juvenile justice play a significant role in conjunction with private service providers. Diverse opinions about process and/or content can create obstacles to successful implementation.

Disagreement about readiness to address issues of reconciliation can hold up the process. Andy, A 12-year-old boy, sexually abused three of his younger siblings. He had been sexually abused by two of his older brothers who were in separate residential treatment facilities. Andy was in his third psychiatric placement in as many months after a five-month stay in a residential treatment program for sexually aggressive youth located about 10 miles from his home. Andy became violent and ran away from his residential facility after hearing that administration stopped his home visits for reasons unrelated to his harmful behavior. He was terrified about not being able to go home and the violent episodes resulted in his placement even farther away. One of the psychiatric hospitals was approximately 50 miles from his home and the other two were over 100 miles away. Andy received numerous medications to reduce his potential for violence.

A private service provider hired by the state to coordinate and facilitate family reconciliation waited weeks for staff to determine when Andy was stable enough for a meeting. Verbal reports only indicated that he became violent and required removal from each facility. Each time he entered a new facility his medications were changed. Finally, the service provider received permission to initiate therapy and contacted the unit to make an appointment. An unidentified staff stated that Andy "was not in a space." When politely asked what that meant, there was silence on the phone, followed by "um, let me see what I can find out." Respectful persistence led to the staff asking Andy personally what he thought about scheduling the meeting. He said that he was fine and was wondering why it had taken so long. The staff scheduled therapy for later that day.

Andy participated actively in the session, identified a pattern of violence related to the terror he felt each time his mother left after a visit with him in the hospital. He identified a high level of motivation to stop the behavior since he knew it was preventing him from going home and created a detailed plan to stop the violence. Andy and the therapist then met with two hospital staff to go over the plan in an effort to engender support for it. He came up with seven ways he could practice calming down and asked the staff to help when he was having a tough time. He also agreed to talk about how frightening it is to think he will never go home. Andy indicated

readiness to hear his older brother's apologies, and to make amends with his little brothers and sister. When asked how the session had been helpful, Andy simply said "the plan." This situation, in which a range of service providers were not equipped to respond adequately, cost significant time, effort, and money that could have been used for more effective intervention.

Communication among all service providers is critical. Professionals and agencies compromise collaboration when they take a unilateral position on any aspect of the content, or process. Unrealistic demands placed on a youth jeopardize successful outcomes.

Many youth write letters of apologies as part of what many refer to as "clarification" (Center for Sex Offender Management, 1999). This is a formal process of activities created for adult offenders, and required in many juvenile programs to acknowledge and take responsibility for sexually harmful behavior. There is a wide range of standards for clarification procedures. If service providers do not communicate congruent expectations or disagree about acceptable levels of compliance trouble can arise.

It is important that the process adheres to factors relating to successful outcomes in psychotherapy (Hubble, Miller & Duncan, 1999) and reflects empathic, warm, genuine, and non-judgmental attitudes at all times. When youth and family members act in good faith and attempt to comply with service provider mandates while receiving messages that what they are doing is not good enough, clients may experience a sense of coercion and/or disrespect. Discord within systems of care increases potential for resistance and dissonance (Miller & Rollnick, 2002) and escalation into disrespect and abuse (Jenkins, 1994).

Professionals working towards reconciliation and reunification without knowledge of the research into recidivism can experience fear of liability and over-estimate the dangerousness of their clients (Prescott, 2006). Over-estimating risk can lead to longer placements and unnecessary attention to peripheral issues such as how much detail a clarification letter requires. It can also cause professionals to focus on task performance rather than skill building, healing, and internalization of concepts such as responsibility, affect regulation, and internal locus of control. Even though there are no validated assessment scales for juveniles who have committed sexual crimes (Prescott, 2006), it is important to use available resources responsibly in an effort to facilitate expedient and successful outcomes.

Attempting to promote harm reduction with youth in residential treatment is hard enough. Attempting to do this with families who may live far away from the residential setting may bring up more logistical issues than programs are prepared to address.

Families

Very little has been written about family reconciliation and reunification with this specific population (Meinig & Bonner, 1990; Thomas & Viar, 1999; Thomas & Viar, 2005). Protocols seldom exist and well-intended service providers struggle to implement meaningful processes without valid and reliable data to guide decision-making and intervention.

One treatment team requested training on transition planning when they acknowledged that they "couldn't let go of the kids." Team members realized they had grown so attached to youth in their residential program that they did not want to see them leave. Addressing this ethical dilemma led them to face the false belief systems they were incorporating into their care with candor. Some of these beliefs included sentiments that treatment team members were better than the youths' families. One staff member stated that he hated the families.

Literature on juvenile sexual offending has provided treatment teams, such as the one mentioned above, a wealth of fuel to feed the fires of such beliefs. A litany of problematic characteristics has been used to describe families with youth who have caused sexual harm.

They have been described as dysfunctional (Araji, 1997), pathological (Bagley & Shewchuk-Dann, 1991), chaotic (Miner, Siekert, & Ackland, 1997), unavailable (Smith & Israel, 1987), characterized by poor communication (Morenz & Becker, 1995; Stith and Bischof, 1996), unstable, disengaged and poorly attached (Weinrott, 1996; Miner & Crimmins, 1995). These families reportedly have high levels of parent-child conflict and marital stress (Bagley & Shewchuk-Dann, 1991; Kimball & Guarino-Ghezzi, 1996), substance abuse and mental health problems (Miner, Siekert, & Ackland, 1997), high incidences of family members who are both perpetrators and victims of sexual abuse and high levels of poverty in the youth's families of origin (Pithers, Gray, Busconi, & Houchens, 1998), histories of childhood abuse, most often experienced within the family context, and witnessing family violence, (Kobayashi, Sales, Becker, Figueiredo & Kaplan, 1995; Ryan, Miyoshi, Metzner, Krugman & Fryer, 1996). If service providers focus only on such vulnerabilities, family reconciliation and reunification become daunting tasks indeed.

The Center for Disease Control (Thornton, et al, 2002) identifies the following vulnerabilities in Families at High Risk for Youth Violence:

- poor interactions between parents and children as early as the first year of life
- emotionally distressed parents involved in anti-social behaviors
- marital conflict and poor communication
- parental criminal and violent behavior
- alcohol and substance abuse
- child abuse and neglect
- harsh inconsistent discipline
- poor parental supervision
- violent neighborhoods
- witnessing violence
- learning problems
- school absenteeism
- bullying, or being the target of bullying
- being arrested before age 14

Finally, the following life experiences that may reflect trauma and influence affect regulation are worth noting as they relate to the youth and families served:

- four types of violence: media, interpersonal, community, structural
- sickness, or accidents
- family dissolution and dislocation
- significant loss
- natural disaster
- poverty
- prejudice
- family problems
- school problems
- Social problems
- divorce
- neglect
- verbal abuse
- physical abuse
- sexual abuse
- terrorism (intimate and public)
- death

Given all of this information, it is no wonder service providers can be reluctant to consider reconciliation and reunification. Embarking on a journey to reconcile pain in such families can

appear overwhelming and demoralizing (Schladale, 2006). Taking on challenges inherent in addressing family violence and sexual harm that may have been occurring for generations often surpasses the training and skill level of service providers. When service providers believe they have little or no power to effect change in family systems such as these, hope and optimism become scarce commodities, and reconciliation and reunification are not priorities. When such belief systems pervade treatment teams, no one wants to return youth to such settings, and negative labels lead to excusing or writing off family involvement.

Acknowledging significant challenges related to family reconciliation and reunification creates a professional environment wherein all service providers, youth, and family members can address fears and qualms about so doing. Acknowledging the brutal facts (Collins, 2001), addressing ambivalence and assessing pros and cons of change may reduce resistance and influence motivation (Miller & Rollnick, 2002).

Creating and maintaining manageable protocols for reconciliation and reunification provide methods for navigating challenging processes. Adherence to protocols can stabilize the process during challenging times. The process begins with a vision, mission, core values, and guiding principles that provide a therapeutic map to guide decision-making.

Vision, Mission and Core Values

Vision

Family reconciliation and reunification with youth who have sexually abused involves *a vision of life free of violence and sexual harm in order to maximize human potential and happiness*. This vision extends to all family, victims, and community members impacted by a youth's behavior.

Creating a vision statement, an established business practice (Collins, & Porras, 1994; Collins, 2001; Covey, 1989), illustrates the concept from sports psychology of visualizing a goal. A good vision statement illuminates the goal for reunification and helps all participants explore what their world will look like when people are no longer violent and/or sexually abusive. Visualizing respectful behavior based upon genuine care, concern, and warm regard helps participants recognize it when it happens.

Fifteen-year-old Lee was in residential treatment for sexually abusing his eight-year-old sister, Katie, and ten-year-old brother, Terry. Katie said she was fearful of Lee and not ready to hear his apologies. A seven-year-old brother, Anderson, had not been identified as one of Lee's victims. During the family systems assessment both children stated that Lee is "sneaky" and they do not trust him.

Terry was ready to meet with Lee and hear Lee's apology for the sexual abuse. Terry said he was not afraid of Lee. On the day of the scheduled apology session, Katie changed her mind and unexpectedly attended the therapy. After Lee finished the apologies and addressed all of the children's questions, the therapist received permission to ask a few of her own. She inquired about Lee's "sneakiness" and wondered about Anderson's fears since he had not been identified as one of Lee's victims. Lee then acknowledged that he had sexually abused Anderson and that "sneaky" was a term used by the children to refer to the sexually abusive behavior. Being "sneaky" was their view of sexually harmful behavior.

The therapist and family now have the task of creating a vision for eliminating sneaky behavior. It is Lee's responsibility to identify what it will look like and how the younger children can recognize it. All of the children will work together to create the language they want to describe the new vision. This language will act as a guide for ongoing assessment and provide a developmentally congruent way to talk about it.

Mission

The mission of family reconciliation is to support all family members in a healing process aimed towards acceptance of and possible forgiveness for any harmful behavior.

The above-mentioned family is currently in the early stages of reconciliation. It is not yet clear whether Lee will be able to return home. Collaboration is occurring across many systems of care. A family therapist specializing in youthful sexual aggression is coordinating the process in conjunction with the children's parents, representatives from the state Department of Health and Human Services, and private residential and community-based clinicians serving all of the children. Future sessions and Lee's progress in residential treatment will inform decisions about a safe return home. While the family is committed to harm reduction, it is not yet clear how they can honor this commitment.

The mission of family reunification is to facilitate a process in which a youth leaving out-of-home care returns to live with biological and/or extended family. This mission requires a family-wide commitment to harm reduction. Detailed tasks for each stage of both reconciliation and reunification processes are the essence of this chapter.

Core values

Core values provide the philosophical foundation from which services are provided. They are necessary to inform consumers about an agency's approach to treatment. Core values guiding the vision and missions of reconciliation and reunification include:

- Every member of a community deserves to be safe. All victims, potential victims, and youth who have caused sexual harm should experience physical and emotional safety. Assessment of safety is ongoing and requires thoughtful response when any change occurs.
- Reconciliation and reunification follow current empirically driven, best practice standards. The field of youthful sexual harm is relatively new and constantly advancing. Best practice standards continually incorporate new research.
- The most effective approach is holistic and collaborative. Addressing complex aspects of youth that may appear unrelated to sexual harm contribute to a youth's overall development and long-term success as a valuable community member. Collaboration among service providers, courts, and families allows youth greater access to resources that can affect harm reduction.
- Reconciliation and reunification are culturally informed. They are processes that utilize the strengths, protective factors, and cultural perspectives of each youth and family in order to best meet their needs for healing and harm reduction.
- Service providers meet licensing requirements and/or specialized training standards for responding to youthful sexual harm. Participating in reconciliation and reunification requires specialized training in order to meet the needs of youth, victims, families, and communities adequately.

Defining the vision, mission, and core values of reconciliation and reunification provide clarity to all participants throughout the process. Should anyone struggle at any point along the way, referral back to these critical guideposts may help individuals work through confusion, misunderstandings and barriers that can inhibit or prevent progress. Core components such as these create a foundation for the following guiding principles.

Guiding Principles for Family Reconciliation and Reunification

- Community safety, victim justice, and sensitivity are the first and overriding concerns of any reconciliation and reunification process.
- Reconciliation and reunification occur in conjunction with social services and/or the juvenile justice system.
- Successful reconciliation and reunification planning begins when a youth is initially referred for services.
- Specialized training is necessary for personnel providing these services and can be provided through interagency initiatives.
- Thorough assessment of each youth's progress in treatment is documented consistently throughout the process. Multidisciplinary treatment team members and social support network members share this document.
- Content of interventions focusing on reconciliation and reunification is determined by need through collaboration among participants.
- Consistent communication is critical among court services workers, juvenile justice personnel, community and residential treatment providers, clients, family and significant social support network members.
- Government systems or agencies mandated to track continuity of care have clearly defined policy, procedures, and protocols for so doing.
- These systems have clearly defined membership on a multidisciplinary transition team and social support network for each youth receiving treatment.
- All parties are clear about what information is communicated (and to whom) at each point in the treatment process.
- Any family members who have been victimized determine the pace of family reunification.
- Each youth has responsibility for leading the reconciliation and reunification process through collaboration with service providers and caregivers.
- Rituals of transition involving all parties punctuate success and collaboration that may enhance a commitment to stop sexually abusive behavior.

Part of establishing a foundation for reconciliation and reunification requires clear understanding of benefits and potential limitations of treatment modalities used to facilitate the process. A multi-modal approach takes advantage of a range of options for enhancing successful treatment outcomes.

Treatment Modalities for Family Reconciliation and Reunification

Multidisciplinary Meetings

Family reconciliation and reunification begin with thoughtful preparation. Permanency planning originates in the juvenile justice system (Judicial Education Center, 1999) and continues throughout residential treatment. Multidisciplinary meetings that always include the youth, parents, or guardians, provide a setting to identify needs, explore resources, obtain support, and plan initiatives. These begin upon a youth's referral for services. Team members become acquainted and have opportunities to build working relationships (Hunter, & Chaffin, 2005). These multidisciplinary meetings should occur on a regularly scheduled basis and focus on assessing protective factors, competencies, strengths, and sources of environmental support, in addition to assessing weakness, deficits, and risks (Henderson, 1996).

While multidisciplinary team meetings may not seem like a therapeutic modality, optimum facilitation can enhance successful treatment outcomes (Hubble, Duncan & Miller, 1999). Youth, parents, or custodians are important participants, possess expertise with respect to their own family, and can provide a vital and guiding force in therapy. These meetings are critical to successful reconciliation and reunification.

Family Therapy

Family therapy is the primary avenue for reconciliation and reunification. It is the venue for openly addressing all pain, trauma, and harm in order to stop secrecy and other factors that feed violence and sexual aggression. It is also the locus for assessing progress and planning steps in the process. Family therapy provides a setting for coaching and modeling respectful communication. It is a venue for introducing safety plans and addressing implementation of emergency responses to high-risk behaviors.

Family therapy is not simply facilitating family meetings. Nor is it staff communication with family members during visits. It is not having a parent or guardian on a telephone during individual therapy or treatment team meetings. Family therapy is a clinically planned, structured process of addressing family problems in an effort to heal pain and stop harmful behavior.

Facilitating a therapeutic process of reconciliation and reunification with youth who have caused sexual harm requires expertise in both family therapy and treatment with youth who have caused sexual harm. Family therapy has received recognition as one of the five qualified mental health professions in the USA. Becoming a family therapist requires intensive academic and clinical training as well as licensure in most states. Providing therapy for youth who have caused sexual harm requires competence acquired by specialized training and clinical supervision for all professionals providing such services. Additionally, it requires credentialing in those states that have statutory requirements. Well-meaning service providers with little or no family therapy training should not facilitate such processes. Family therapists with little knowledge of youthful sexual offending do not have sufficient expertise to facilitate such processes. Facilitation should occur in a context of collaborative clinical supervision among specially trained and credentialed clinical supervisors and licensed mental health professionals.

Individual Therapy

While the Office of the Surgeon General (2001) has identified it as ineffective in reducing youth violence, individual treatment can be an adjunct in family reconciliation and reunification to support the family therapy. Clinicians may need individual time with some family members in order to explore motivation and readiness for change. Delicate issues relating to violence and/or sexual abuse require sensitive exploration in order to maintain affect regulation. There are also times, as identified in the following therapeutic considerations, when youth and family members may need individual time to explore concerns they may not be ready to address with other family members. Youth need practice in preparing to make amends (Jenkins, 1990) in order to prevent harmful behavior in therapy sessions. Individual preparation can reduce the potential for harm and model skill building for participants.

Andy, a young man identified previously, had two individual sessions with the treatment coordinator before participating in apology sessions and family therapy. The first session was to assess his psychological stability and amenability for family reconciliation. The second was to assess his readiness to participate in apology sessions with his brothers who had sexually abused him, assess motivation to begin making amends to the siblings he had sexually abused, and create a plan for multi-sensory self-soothing to enhance affect regulation and reduce disturbances of arousal (Stien & Kendall, 2004; van der Kolk, 2004).

Treatment modalities require flexibility to meet the needs of all family members throughout the process. Continuous assessment can assist decision-making; it can include information obtained in each multidisciplinary meeting, individual, and family therapy session. When these modalities are facilitated by a range of mental health professionals in a variety of clinical settings it is imperative that they all share the same vision, mission, core values, and guiding principles in order to ensure a congruent experience for everyone. Alignment becomes

threatened when service providers are at odds.

Initial Therapeutic Considerations

Once a solid foundation for reconciliation is in place, a variety of issues are considered. Prior to treatment families have seldom communicated about sexual abuse in a healing manner. Youth involved in the juvenile justice system may receive instructions not to talk about it by an attorney. Youth, victims, and family members may become overwhelmed by the investigative process and exhibit disturbances of arousal or affect dysregulation involving explosive and/or constricted affect (Schladale, 2006; Stien & Kendall, 2004; van der Kolk, 2004). Everyone who may potentially be involved in the reconciliation process participates in a family systems and ecological assessment in order to establish a framework for the process.

Before engaging family members in treatment, the following require consideration:

- Direct interaction among all family members about very sensitive material may not be advisable during initial phases of consideration for family reconciliation.
- Family members initially may not be able to discuss questions and concerns in family sessions; individual, parent and/or caregiver meetings can be helpful in this regard.
- Early in treatment, a youth may not be able to answer many questions and concerns that victims and non-offending family members have.
- Initially family members may not be able to answer questions posed by the youth who has offended.

Family Systems and Ecological Assessment

Most assessment of youthful sexual harm focuses on individual risk factors. Only recently have scales integrated concepts from human ecology and life course research into the process (Prescott, 2006). While individual assessment is critical to successful treatment, it will only be addressed here in the context of family reconciliation and reunification.

Initial assessments focus on how a youth came to cause sexual harm, individual and family strengths and vulnerabilities that can influence treatment outcomes, risk factors for re-offense, protective factors that mitigate risk, and recommendations for intervention. When youth are placed in residential treatment, continuous assessment shifts focus to address treatment progress and freedom of movement such as community visits.

Determining potential for family reconciliation and reunification requires assessment of social support, elements of environmental protective factors (Bremer, 2006; Henderson et al., 1996), and settings that support young people's development (National Research Council and Institute of Medicine, 2001). Assessment throughout this part of the treatment continuum addresses a graduated process of community reintegration, termination of residential care, and utilization of community-based services. Family, school, and relevant community entities such as churches, social outlets, sports activities, and systems of care make up a youth's ecological context. The following information highlights important elements to be assessed for reconciliation and reunification.

Assessment

In all ecological contexts, youth should be assessed for:

motivation for change
affect regulation

ability to perceive and access social support
mentorship

| | |
|------------------------------|---|
| strengths vulnerabilities | resiliency social learning: values and beliefs |
|------------------------------|---|

A youth's biological and extended family system provide critical information about:

| | |
|---|---|
| family life cycle attachment and connection developmental milestones sexuality affect regulation and coping strategies nutrition | family history physical health mental health abuse and criminal behavior addictions |
|---|---|

Information obtained from a youth's school should include:

| | |
|--------------------------------------|---|
| intellectual capacity performance | attendance extra-curricular activities (sports, clubs) |
|--------------------------------------|---|

Assessment of spiritual beliefs and/or church address:

| | |
|--|------------------------------|
| values and beliefs affiliation and membership | participation and attendance |
|--|------------------------------|

Community assessment includes:

| | |
|---|--|
| extracurricular activities leisure time and recreation sports | clubs/gangs structured activities participation and attendance |
|---|--|

Systems of care assessment involves:

| | |
|---|--|
| judicial services supervision and surveillance support services | activity and rationale participation and attendance |
|---|--|

Affect regulation

A significant component of assessing potential for family reconciliation and reunification involves affect regulation. Affect regulation is a person's ability to manage emotions without causing harm (Schore, 2003). When people do not learn pro-social ways to manage upsetting emotions they are at risk of behaving in harmful ways. Dysregulation occurs when individuals manage emotions in ways that cause harm to self or others.

Humans experience many forms of arousal. A range of emotional and sensory stimuli, including, but not limited to joy, fear, pain, hunger, thirst, temperature, love, sex, loneliness, and/or terror can all influence arousal. Some of these stimuli, such as fear, can also influence sexual arousal. Everyone is challenged to regulate arousal in pro-social ways. Disturbances of arousal occur through dysregulation. Violence and sexual harm are two types of dysregulation.

Determining potential for family reconciliation requires assessment of affect regulation and disturbances of arousal in all pertinent family members and social support network members. Affect regulation is central to healing the wounds of sexual abuse. Harmony, a core component of reconciliation, involves congruence and order. Dysregulation is incongruent with reconciliation as it threatens elements of optimum child development by endangering emotional and physical safety for everyone involved. It is important to model pro-social coping

strategies when family members display disturbances of arousal in order to reduce harm and enhance potential for reconciliation and reunification. Therapists can compromise reunification and successful treatment outcomes by not taking the time to do so. This issue receives further attention later in the chapter.

Elements of optimum child development:

Elements of optimum child development (National Research Council and Institute of Medicine, 2001) identified earlier in this chapter provide important information for assessment regarding reunification. The following document provides an informal way of addressing these elements with each family. It is important to note that the document is not a valid and reliable assessment scale but a simple format to organize information about these evidence-based factors to inform decision-making. The information can also be changed to a self-report document for parents, guardians, and social support network members.

Characteristics of Settings That Support Young People's Development
(National Research Council and Institute of Medicine, 2001)

On a one to ten scale (1 = not at all, 10 = very well) how well do you think this family is meeting the needs of each child being served?

Physical and Psychological Safety: 1 2 3 4 5 6 7 8 9 10

Appropriate Structure: 1 2 3 4 5 6 7 8 9 10

Supportive Relationships: 1 2 3 4 5 6 7 8 9 10

Opportunities to Belong: 1 2 3 4 5 6 7 8 9 10

Positive Social Norms: 1 2 3 4 5 6 7 8 9 10

Support for Efficacy and Mattering: 1 2 3 4 5 6 7 8 9 10

Opportunities for Skill Building: 1 2 3 4 5 6 7 8 9 10

Integration of Family, School
and Community Efforts: 1 2 3 4 5 6 7 8 9 10

Now, please identify what might be done to improve efforts in each of the designated areas.

Physical and Psychological Safety:

Appropriate Structure:

Supportive Relationships:

Opportunities to Belong:

Positive Social Norms:

Support for Efficacy and Mattering:

Opportunities for Skill Building:

Integration of Family, School, and Community Efforts:

Motivational Interviewing

Motivational interviewing is a therapeutic intervention designed to enhance successful treatment outcomes and sustain change over time (Miller & Rollnick, 2002). Core components of motivational interviewing can provide important information for assessment focusing on reconciliation and reunification. Motivational interviewing places emphasis on clients being ready, willing, and able to change. Assessing these factors in each family member can illuminate resistance, ambivalence, and – most importantly – provide a foundation from which to begin intervention and efforts to promote life-long change.

Integrating these concepts into this work can provide important predictive information. Asking participants to rate the importance of family reconciliation and their confidence level in achieving it may predict potential for change (Miller & Rollnick, 2002). The same questions can inform reunification efforts.

Assessment for family reconciliation attempts to glean information relevant to family support and functioning in order to determine potential for healing and possible forgiveness. It addresses the vision of a life free of violence and sexual harm in order to inform interventions necessary to do so. Assessing individual strengths, motivation, and environmental resources provides information used to consider how a youth and family can enhance potential for success and happiness. This assessment guides both the process and content of family reconciliation and decision-making about reunification. The following information is interwoven with the assessment and much of it can be obtained concurrently as the assessment unfolds.

Preliminary Preparation For Family Reconciliation

- Determine who is willing to consider any involvement in family reconciliation and create a roster of those people.
- Explore any restraints or ambivalence that each person has to considering family reconciliation and/or reunification.
- Explore how successful past family discussions have occurred and how future ones can improve.
- Explore with each individual how a family discussion about reconciliation might go.
- Support each person in practicing their approach for insuring that meetings proceed with respect for all family members in order to enhance successful outcomes.
- Allow each person to imagine questions others will have, and how the questions might best be answered.
- Encourage each family member to explore a variety of resources for obtaining answers to all of the questions.
- Create a plan of action for dealing with problematic behavior if it occurs in a meeting.
- If the youth's victim/s want to participate, make sure that protocols for victim apologies and making amends have been completed and that safety plans are established and maintained.
- Prepare all participants to manage difficult affect through multi-sensory self-soothing techniques such as taking deep breaths, requesting a break during the meeting and/or pre-arranged coping strategies.
- Once all preparation is complete, schedule family and/or social support meetings with all pertinent members.

Upon the establishment of a stable foundation for reconciliation, the actual process begins. Flexibility among all participants can greatly enhance outcomes. Logistics among diverse multidisciplinary service providers and a broad array of family and social support network

members can be quite challenging.

Lee's story is mentioned above. There are seven children in this blended family. Each parent was previously married. The mother's former husband is deceased, and the father's ex-wife is an active drug dealer with whom the eldest son resides. The eldest has had no contact with any other family members since the sexual abuse investigation, and he awaits adjudication. The two involved parents are loving, diligent, and committed advocates for all of the children.

All seven of the children have been sexually abused and all except the youngest, seven-year-old Anderson, have sexually abused their siblings. The three in residential treatment have therapists and case managers assigned to them. Three children at home share a community-based therapist and are involved in a therapeutic after school program. Family preservation services are provided, and the state contracts with a private agency to facilitate case management for the entire family and system of care. Additionally, a previously mentioned specialist is facilitating family reconciliation and possible reunification. At any given time, there are seven licensed mental health professionals and four service providers focusing on case management. Two state employees monitor child protection and funding.

Scheduling meetings among participants has potential to become a logistical nightmare. Core values of the mission have provided a foundation of respect that enables participants to address scheduling conflicts and diverse thought about treatment without rancor. The most difficult challenge has been communication with staff at the short-term psychiatric hospital where Andy has been for several weeks. While the rest of the team has gotten to know each other and work collaboratively, the psychiatrist and psychiatric social worker are not engaged participants. The inability to communicate effectively periodically causes this part of the process to be out of alignment. Everyone works to the best of their ability to maintain equilibrium and facilitate a safe and stable process. Key elements of such a process involve the following:

A Process for Family Reconciliation

- Family meetings occur in any location that provides physical and emotional safety as well as clinical confidentiality.
- They may include all family members and any social support network members upon whom everyone agrees.
- Not everyone has to participate in every meeting.
- Family members not previously willing to participate are welcomed, if they change their mind and go through preliminary preparation.
- The family establishes overall goals for family reconciliation in the first session.
- Family members are asked to identify what reconciliation will look like for them. This provides an opportunity to visualize the goal and create measurement criteria.
- Once goals and a vision are established the facilitator clarifies if and how reunification may fit into this picture.
- Assessment of progress towards the established goals takes place at the beginning of each following session. This can be formally documented or addressed informally by asking, "How are things better since we met last?"
- Individual session goals are identified at the beginning of each meeting, and achievement measured at the end of each session. This can be formally documented or addressed simply by asking, "How has our time together today been helpful?"
- Ongoing assessment of the healing process influences discussion about possibilities for reunification.
- If victim/s are in the home, have been participating in family reconciliation, and want the youth to return home, then family reunification is considered.

- If victim/s are not in the home, the youth and all family members want reunification, the process begins.
- If victim/s are in the home and are not willing to have the youth return home, or the treatment team (including family members) determine it is not safe for the youth to return home, alternative living arrangements are explored and plans for continued family contact are created.

There is a range of reasons that family reunification may not be an option. Disability, psychiatric disorders, substance abuse, poverty, and/or overwhelming stress may prevent adequate supervision and child protection. Acceptance and possible forgiveness can help family members reconcile the pain of sexual abuse while being unable or unwilling to have a youth return home.

Reunification may remain a future possibility as youth transition from residential treatment into a less restrictive setting. When this is the case, continuity of focus on family reunification should remain stable throughout such a process of change. Monitoring change in any barriers to reunification informs continuous assessment and guides decision-making. Each regularly scheduled treatment team meeting addresses the status of reunification until the team can make a final decision.

When family reunification is ruled out, youth, family, and social support network members receive support in exploring alternative living arrangements for the youth. Formal plans can be created to ensure ongoing support and visitation. Since social support is a significant protective factor for violence prevention (Bird, Stith, & Schladale, 1991; Thornton et. al., 2002; Office of the Surgeon General, 2001) it is imperative that each youth be provided with continuity of care until that time when he or she has established stable relationships in the new setting. Residential treatment personnel can do this through a documented telephone tree wherein designated staff make scheduled calls to a youth in order to affirm support throughout the transition period. Clinicians may continue therapy on a graduated basis to bolster stability and enhance potential for long-term successful treatment outcomes.

A Process for Family Reunification

Successful family reconciliation often leads to family reunification. When this occurs, there is still a lot of work to do. This can often be a time of great expectations and great trepidation! For helping professionals there is no greater thrill than witnessing a healing process.

Experiencing the honor and privilege of seeing youth and family members reject violence and sexual abuse in their lives illuminates intrinsic motivation and provides hope for sustained change.

The lack of evidence-based practice can make family reunification a scary prospect and the barriers described above give pause to such an undertaking. Good things can happen when clinicians are able to proceed with caution while continuously assessing both the process and content of a reunification experience. Facilitating a process for family reunification requires thoughtful diligence and collaboration among all stakeholders. The following components provide a framework for so doing.

Social Support Network

As mentioned previously, social support is widely considered a critical element of youth violence prevention (Bird, Stith, & Schladale, 1991; Thornton et al, 2002; Office of the Surgeon General, 2001). Using this factor in a variety of ways can maximize potential for success. Hopefully, residential treatment programs identify potential social support network members as soon as youth come into treatment and engage participants throughout the full continuum of care (Schladale, 2006). This is a fluid process as the network expands and/or contracts based

upon relationships, proximity, and access.

In order to support a youth throughout transition from residential care and reunification, all treatment team, family, and social support network members have full knowledge of a youth's risk and protective factors, patterns of harmful behavior, and plans for continued success. All family and social support network members have publicly committed to report any potentially harmful behavior to designated treatment team members or local authorities. And all family and social support network members have documented plans for involvement and specific interventions if the youth is struggling in their presence. A safety plan, addressed in detail later in the chapter, is created and monitored by all participants.

A young man named Leonard committed a rape at his high school. He was adjudicated and sentenced to a two-year commitment in a local maximum secure facility. By the time he was discharged, his social support network consisted of his single mother, her minister, his high school football coach, history teacher, and probation officer. Leonard had the full support of his multidisciplinary treatment team at the facility, who collaborated with him on a formal graduated transition plan. Leonard was returning home to his mother and his old high school.

His final social support network meeting, just prior to discharge, consisted of everyone reporting on the specific involvement each would have in promoting harm reduction. This was referred to as his "Plan for Continued Success." It was a creative and fascinating plan. Leonard was a self-described atheist and wanted his mother's minister as part of his social support network because his mother was a devout Christian who had received enormous support from her minister throughout the ordeal surrounding the rape. Leonard knew that the support his mother received from the minister was critical in her ability to support Leonard.

Leonard's football coach agreed to all of the terms for membership on the social support network and documented the following plan for involvement and intervention. He and Leonard agreed that every day at 3:21p.m., when the final school bell rang, Leonard would walk past the coach's office and call out a greeting that the coach would acknowledge. Before the rape, Leonard had a habit of doing just that. On the day of Leonard's arrest and removal from the school, the coach had wondered where Leonard was when he didn't pass by and call out to the coach. The coach had never forgotten that day and reported that he would know Leonard was not in any trouble if he kept to the long established routine. If the coach did not see Leonard, he was to implement a tracking protocol that Leonard had created.

A well functioning social support network relies on pragmatic, solution-focused means to maintain connection, mentor, and monitor adherence to a youths' plan for continued success.

Affect Regulation

Affect regulation plays a critical role in the process of family reunification and warrants further attention here. Monitoring affect regulation provides the cornerstone for assessment and therapeutic decision-making. Youth and family members' ability to manage emotions without causing harm to self or others determines the success of reunification. Stien and Kendall (2004) identify the following strategies for enhancing affect regulation:

1. safety and stabilization
2. symptom reduction and memory work utilizing cognitive stimulation through multi-sensory therapies to include:
 - exercise and body movement
 - healing touch

- expression through art, drama, dance and music
 - narrative trauma scripting
3. developmental skill building

Youth and family members are taught multi-sensory coping strategies for self-soothing (Stien & Kendall, 2004; Van der Kolk, 2004) before home visits occur. This is a core component of affect regulation and involves the following tasks for harm reduction (Van der Kolk, 2004)

- mindfully observe internal experience.
- stay organized in the threat of psychological upheaval.
- change body state when addressing deepest pain.
- learn to state success.
- remember and use preferred multi-sensory coping and/or survival strategies.
- celebrate coping and/or survival resources.
- honor their life.

The youth can begin community reintegration once a thorough assessment has established that home visits will be safe and stable, that multi-sensory coping strategies are in place and in practice, and that the youth is engaged in social and cognitive skill building.

Safety Plans

Safety plans are clearly defined documents used to illuminate the vision for family reunification. They provide a map for illustrating new and safe routes for navigating family interaction previously fraught with the dangerous road conditions of trauma and abuse. A good safety plan identifies all known barriers, detours, and dangerous impediments that can cause a break down on the road from residential treatment to a life lived respectfully, free of violence and sexual harm.

The following framework may assist service providers in both the process and content of developing effective plans.

Creating and Facilitating Safety Plans

1. What is the goal of the safety plan?
2. What are the specific behaviors the safety plan should enhance?
3. What are the specific behaviors the safety plan should stop?
4. Who will be involved in the safety plan?
5. What will each person do to ensure successful implementation of the safety plan?
6. How will the elements of each safety plan be decided?
7. Will the elements be decided all at once, or on an ongoing basis?
8. What are all of the elements of the safety plan?
9. What is the relationship of each element in the safety plan to harm reduction?
10. How does each element of the plan reflect evidence-based practice?
11. Who will make decisions about implementation and follow-up?
12. What preparation time is required to set the safety plan in motion?
13. What materials will assist the team in carrying out the safety plan?
14. Where are these materials kept?
15. Who is responsible for these materials?

Leadership

1. Who will facilitate the safety plan?
2. What is the rationale for choosing each facilitator?
3. What role will each facilitator have in the process of the safety plan?

4. Will that role be flexible or fixed?
5. How will any challenges in the facilitation process be addressed?
6. If there is conflict between facilitators who will mediate?
7. How will transitions in leadership be handled?

Structure

1. Who will participate in the safety plan?
2. Will the time frame for the safety plan be flexible, or time limited?
3. If it has a designated length of time how is the time frame decided?
4. How often will participants meet to assess the safety plan?
5. On what days of the week will a meeting occur?
6. What time will the meeting begin and end?
7. Who will facilitate the safety plan meeting?
8. If they are not available who will facilitate the meeting in their absence?

Process and Planning For Continued Success

1. How will each safety plan meeting start?
 2. How will the success of the plan be measured?
 3. Who will be responsible for documentation of the safety plan?
 4. What will the documentation look like?
 5. Where will documentation be kept?
 6. What information from each meeting will help in the planning for the next safety plan assessment?
 7. Who will take responsibility for any tasks necessary to ensure successful implementation of the next phase of the safety plan?
-

The following sample safety plan is provided as a template. Each "safety plan element" and the following five related factors (relation to harm reduction, evidence, facilitator, preparation, and materials) are duplicated as needed to match the number of elements for each youth's plan.

Safety Plan

Name: _____ Date: _____

Safety Plan Goal:

Specific Behaviors To Be Enhanced:

Specific Behaviors To Be Stopped:

Safety Plan Participants:

| | |
|-------------------------------|---------------------|
| Name | Support To Be Given |
| <hr/> <hr/> <hr/> <hr/> <hr/> | |

Safety Plan Element:

Relation To Harm Reduction:

Evidence:

Facilitator for implementation and follow-up:

Preparation Time:

Materials and Location:

Facilitators of the Safety Plan:

| Name | Rationale | Tasks |
|-------|-----------|-------|
| <hr/> | <hr/> | <hr/> |

Safety Plan Meetings:

Date Location Time

Safety Plan Strengths:

Safety Plan Vulnerabilities:

Goals Met:

Continued Challenges:

New Goals:

Time Frame For Goals:

Signatures of Participants:

Once safety plans are documented home visits are planned and scheduled.

Home Visits

State-dependent learning is a phenomenon addressing the impact of context, condition, and environment on learning and memory retention (The American Heritage Stedman's Medical Dictionary, 2004). It is based on a belief that the "state" in which something is learned influences the recall of knowledge gained in that state. Information may only be recalled later if the original state of learning is restored. One example from the field of substance abuse is the notion that something learned under the influence of drugs or alcohol is difficult, if not impossible to recall in a sober state. It also applies to certain prescription medications. When youth are medicated and learn new information, they may only be able to retain such information while under the influence of the designated medication. If a youth learns to sexually abuse in a stressful home or community environment and learns harm reduction strategies in a significantly altered state (such as a residential setting), it may be difficult to access resources necessary to implement affect regulation back in the home environment.

If the greatest plan for continued success does not work in practice, it most likely will not work after discharge. It is therefore necessary that youth have many opportunities to practice harm reduction in the community setting where they will be returning. Home visits are the foundation for such practice.

Graduated furloughs or home visits are always scheduled and documented in accordance with licensing and credentialing bodies. Responsibility for supervision and monitoring is clearly assigned, documented, and assessed on a continuous basis. Intervention plans are documented in the event that the visit is threatened by disturbances of arousal leading to dysregulation. On-

call staff are identified and contact information is provided for all family and social support network members. Any therapeutic tasks assigned for the visit are clearly communicated and documented.

A “debriefing” with designated service providers follows each home visit. This may occur with the family as a whole, individuals, and/or any pertinent family subsystem.

Debriefings should include, but are not limited to the following discussion topics:

- highlights of the visit (activity, participants, what made it a highlight, etc.)
- low points of the visit (activity, participants, what made it problematic, etc.)
- if any criminal behavior is revealed, focus shifts to reporting protocols
- status of therapeutic tasks
- coping strategies used for handling any stress and conflict
- strategies for reducing conflict during future visits
- challenges with any urges to commit criminal acts. If so, what specific crimes, contextual factors such as family dynamics, and - most importantly - what self-intervention took place to prevent any crime from being committed.
- planning for continued success during future home visits

Future home visits and length of stay are scheduled in response to information obtained through the debriefing process. Duration increases in a step-wise fashion when assessment indicates success. When a youth's visits use the maximum time allotted by credentialing or licensing bodies it is time for the process to move forward.

Transition Planning

Demonstration of consistent pro-social behavior throughout all furloughs indicates time for transition planning and discharge scheduling. A multitude of logistical arrangements is coordinated through collaboration among all service providers, youth, family, and social support network members. Family therapy focuses on any unfinished tasks and “to do” lists are often created and monitored for completion. Such tasks may include a broad range of activity from school and/or work transitions to obtaining a driver’s license.

During this time, many programs support youth in creating and facilitating rituals associated with discharge from residential treatment. Collaborating with a youth and family to develop a poignant and meaningful experience can punctuate ambivalence about the process; fear of, and motivation for change; hopes and expectation about the future. Such rituals can symbolically illustrate how a youth and family are experiencing the process and provide valuable information for assessment and decision-making. Some families record these rituals and plan future anniversary celebrations to honor change and the healing experience.

As these activities are occurring, the team can arrange aftercare services. Evidence-based practices for violence prevention that may include intensive home-based services such as Multisystemic Therapy (MST) show promise as community-based initiatives (Borduin & Schaeffer, 2001).

Continuity of care is a significant challenge during this part of this process. Leichtman and Leichtman (1999) identify the following concerns about residential treatment for children:

Studies show that, although most children and adolescents improve, their gains are frequently lost after discharge, and improvement during treatment does not predict subsequent adjustment (Allerhand, Weber, & Haug, 1966; Curry, 1991; Lewis, Lewis, Shanok, Klatskin, & Osborne, 1980; Quay, 1979, 1986; Taylor & Alpert, 1973). These results, it should be noted, hardly come as a surprise to clinicians. All too often they witness youngsters who blossom in the safe, structured, and nurturant milieus the best residential facilities provided flounder

when transplanted into the radically different environments of their home communities (P. 83).

Rarely do youth who have caused sexual harm receive services from a consistent multidisciplinary professional team. Agencies seldom provide or employ clinicians to facilitate both residential and community-based services. Youth and families are at risk of being handed off as a baton in a relay race across a full continuum of care served by a range of professionals coming and going in the lives of clients.

Collaboration and sensitivity to a youth and family's needs are most essential during this time. Scheduling appointments for aftercare services can bring up dreaded anticipation of involving new and unknown service providers in the process. While youth and family members may be thrilled about healing the pain of sexual abuse they may also tire of a long process of investigation, adjudication, and residential treatment that may have felt like having a wary eye watching and assessing everything they do. They may fear beginning anew with service providers who require them to "start over." When youth and family members have experienced disrespect at any point throughout the systems of care, they are understandably circumspect. Addressing the full range of emotions that everyone, including staff, is feeling can go a long way in preventing unnecessary roadblocks throughout reunification.

When all of the above-mentioned elements come together, it is time for a closing celebration and discharge from residential treatment. The transition plan includes formal pre-scheduled contact with primary staff after a youth returns home.

While some programs have no-contact rules in a misguided attempt to prevent boundary violations, such policies violate continuity of care and are at risk of creating a heightened sense of disconnection and isolation from powerful mentors and role models in the lives of these youth. Planning and documenting scheduled contact eliminates potential ethical violations regarding dual relationships. When protocols address professional relationships between services providers and clients with well thought out policies that guide all interaction, youth and social support network members receive assurance that they are not being abandoned and left to their own devices for harm reduction. Like adult children leaving home, successful launching necessitates a flexible process of increasing independence in order to establish safety and stability for a bright future. Termination of contact after lengthy stays in residential treatment risk making youth feel like they are dropping off the face of the earth. Such thoughts can be terrifying enough to cause disturbances of arousal, dysregulation, and heightened risk of harm.

Scheduling telephone contact and formal meetings or visits may reduce anxiety about losing valued relationships developed during a youth's length of stay. Having designated staff participate in transitional meetings or therapy sessions with new service providers may ease possible discomfort and awkwardness. Finally, transition planning involves identifying and documenting protocols for monitoring progress, notifying others if success is threatened, returning to residential care if necessary, and tracking outcomes.

There are some differences in reunification when victims reside inside versus outside a youth's home. Procedures remain the same except for the following distinctions.

Reunification with Victim/s in the Home

When victim/s, or any vulnerable family members want a youth to return home, the process of reunification begins only after victim apologies, reconciliation and restitution have occurred. If any victims do not have therapists, it is imperative that they are engaged in the therapeutic process with the mental health clinician facilitating reunification.

In addition to all of the reconciliation and reunification factors previously listed, this work involves continuous communication about safety and stability with any victims residing in the

home. In family therapy the youth and any victims address all behaviors that make a victim feel physically or emotionally unsafe. These are documented and become part of the safety plan. Further planning involves identifying what a victim will do when they feel physically or emotionally unsafe in any way. This involves identifying how they will respond, who they will tell, and what that person will immediately do with the information. Such planning also involves identifying a youth's responsibility if a victim identifies a lack of safety. Planning for what a youth will do when a victim feels unsafe clarifies a youth's responsibility for rectifying the situation and places the onus where it belongs.

After visits, debriefing with victims is paramount and guides future planning. Depending upon a victim's age and relationship with service providers, trusted parents, or guardians can communicate information to designated treatment team members. Such important information always receives documentation. If at any time a victim indicates vulnerability, contact stops until physical and emotional safety for everyone returns.

When victim/s express readiness for a youth to earn the privilege of returning home, scheduling discharge begins. The pacing of this process can be challenging as ambivalence is explored, and victims (and other family members) wrestle with such important decisions and possibly change their minds temporarily or permanently. Continuously assessing readiness, willingness and ability (Miller & Rollnick, 2002) remains a vital part of the process at this stage.

Reunification When Victim/s Do Not Reside in the Home

When any victim/s are in the extended family, neighborhood, school, church, or broader local community and contact is allowed special consideration is necessary. Victims and their parents or guardians are invited to participate in a restorative justice process that addresses their needs for information, truth telling, empowerment, and restitution or vindication (Zehr, 2002). When the youth successfully meets this obligation, family reunification can proceed.

If a youth will possibly have contact with any victims upon return to the home community, designated service providers are responsible for communicating this information to the victims and/or their parents or guardians. When necessary, meetings occur with victim/s or their parents or guardians to address any concerns related to the youth's return and to support their preparation for any potential contact with the youth. Victim/s, and and/or their parents, or guardians, are provided with notification information and instructed to notify authorities if there is any potentially harmful interaction with the youth. A youth is responsible for doing everything in his or her power to prevent unplanned contact with any victims.

No Contact Orders

The following work takes place prior to a youth's discharge from residential treatment.

When a no-contact order is in effect, detailed plans are made and documented, outlining a protocol for immediate reporting if the order is inadvertently or purposefully violated. Such information is part of the formal safety plan for home visits and a permanent component after discharge. The plan includes stipulations for contact initiated by a youth or by a victim.

If unreported victim contact is discovered prior to discharge from residential treatment, visits are halted until the youth demonstrates contrition, makes amends (real or symbolic), and recommits to honest communication with treatment team, family, and social support network members.

If any violation occurs after discharge, a youth's probation officer is notified immediately. The officer can then address sanctions with the youth. When juvenile justice is not involved, designated service providers, family, and/or social support network members have a

documented plan for responding with pre-arranged consequences.

Conclusion

Family reconciliation and reunification with youth who have caused sexual harm are complex processes with no evidence-based practices to serve as guides. Dedicated collaboration is necessary among residential treatment staff, youth, family, and social support network members, and community-based systems of care to enhance successful treatment outcomes that influence community safety. Service providers intent on maximizing therapeutic effectiveness will do well to maintain a thoughtful approach to planning, documentation, and implementation of activities that can enhance healing and elimination of harmful behavior.

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