Process Evaluation of the Colorado Sex Offender Management Board *Standards and Guidelines*

A REPORT OF FINDINGS
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EXECUTIVE SUMMARY

This report is a first step in meeting the legislative mandate requiring an evaluation of the effectiveness of the SOMB's Standards and Guidelines ((C.R.S. 16-11.7-103(4)(d)(I) and (II)), (referenced in detail in Section One). Evaluating the effectiveness of any program or system first requires establishing whether the program/system is actually implemented as intended and, if so, the extent to which there may be gaps in full implementation. A process evaluation examines the question of implementation and necessarily precedes an outcome or effectiveness study. Information for this study was obtained from 191 90-minute interviews and comprehensive reviews (using 18-22 page data collection instruments) of 114 case files.

The second step in evaluating effectiveness requires a study of the behavior of offenders managed according to the Standards and Guidelines. The second study will be undertaken as resources allow.

Recommendations to improve the implementation of the Standards and Guidelines follow the executive summary.

- **The *Standards and Guidelines* are implemented sufficiently to warrant an outcome evaluation study.** As the summary below reflects, significant efforts are underway in the community to manage adult sex offenders, and these efforts are guided by the description of policies and procedures in the *Standards and Guidelines.* However, many treatment providers must improve the documentation related to their work to ensure that program evaluators have access to sufficient information to study the relationship between services delivered and offender outcome.

- **Professionals working with sex offenders found the *Standards and Guidelines* to be useful to them.** During telephone interviews, 92.2% of 64 treatment providers and 98.1% of 110 probation and parole officers said that the *Standards and Guidelines* were useful in their work with adult sex offenders. In an unstructured portion of the interviews, nearly two-thirds (63.6%) of the supervising officers said the *Standards and Guidelines* gave them direction in their work and provided support in the management of offenders; over one-third said community safety was improved and offenders were held more accountable. Both groups valued the *Standards and Guidelines* for standardizing management practices and for being based on research.

- **Many of the professionals who are directed by the *Standards and Guidelines* reported that they had participated in their development, reflecting the intent of the SOMB to be inclusive in its work.** Nearly ten percent of supervising officers, one-third of therapists, and two-thirds of the polygraph examiners said they had served on a SOMB Board subcommittee; many more had attended meetings of the SOMB Board over the years.

- **Successful efforts are being made to provide judges with adequate information at sentencing.** Fifty-three pre-sentence investigation reports prepared by supervising officers were found to provide excellent descriptions of offenders, particularly in the areas of criminal history, substance abuse and education. Forty-five Mental Health Sex Offense-Specific Evaluations (MHSOSE) were carefully reviewed by researchers and were found to be comprehensive and thorough, but copies of the evaluations were not always present in professionals' files after offenders received community-based sentences. Also, mental health evaluators are required to include in the MHSOSE a recommendation regarding the appropriateness of community placement, based on the information obtained during the evaluation only 29% of the reports addressed the issue.

- **Treatment appears to be a significant intervention in the lives of sex offenders under supervision in the community.** Information was readily available regarding treatment providers' general expectations of offenders, as well as the offenders' attendance in treatment. The *Standards and Guidelines* would be more fully implemented if all treatment plans were individualized and included goals with measurable objectives and a plan to achieve those objectives. Such treatment plans are considered best practice and are required by professional societies. Further, complete documentation of case management is required to study the impact and "analyze the effectiveness" of the *Standards and Guidelines* per C.R.S. 16.11.7-103(d)(I).

- **Interview data obtained from treatment providers and supervising officers reflected a significant exchange of information about sex offenders.** This communication is commonly but not always documented in the files; improved recording of case activities in the files will enhance future research efforts to link specific aspects of team collaboration to client outcome.

- **Professionals mentioned many barriers to the full implementation of the *Standards and Guidelines.*** The need for training, the lack of clarification of a few of the *Standards and Guidelines,* and the loss of supervising officers in the current budget reductions and the corresponding excessive caseloads were mentioned as barriers to full implementation. However, many professionals described a variety of ways they sought to overcome impediments to implementation.

- **Some evidence suggests that supervision plus treatment of offenders on parole may reduce recidivism as measured by new arrests.** A recent study tracking sex offenders released from prison found that those who received parole supervision and treatment as required by the *Standards and Guidelines*, compared to sex offenders who discharged from prison and did *not* receive supervision and treatment, were 40% less likely to get arrested for a violent crime in the year following release. The violent rearrest rate was low for both groups (14% for the group that discharged and 8% for those who received parole supervision and community based treatment) but the difference was significant and translates into greater public safety. The violent rearrest rate drops to 1% when paroled offenders have participated in very intense sex offender treatment in prison.

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SECTION ONE: INTRODUCTION

Background

In 1992, the Colorado General Assembly created the Sex Offender Treatment Board to develop standards and guidelines for the assessment, evaluation, treatment and behavioral monitoring of convicted adult sex offenders who are under the supervision of the criminal justice system. In 1998, the name was changed in statute to the Sex Offender Management Board (SOMB) to better reflect the purpose and duties assigned to the board. The SOMB's *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* were first published in January 1996. The *Standards and Guidelines* were revised in 1998 to include new research and evolving clinical practices. In addition, appendices were added or modified in July 2002 to clarify issues that surfaced during implementation. In 2004 a revised version of the *Standards and Guidelines* for convicted adult sex offenders will once again be published by the SOMB, reflecting a document that evolves as new information becomes available. Funding for much of the work accomplished by the SOMB has come from a portion of the sex offender surcharge fund (C.R.S. Article 21). This fund assesses fees ranging from $150 (class 3 misdemeanor) to $3,000 (class 2 felony) on offenders convicted sex offenders (including those granted a deferred judgment).

Purpose of this Report: A Process Evaluation

This report is a first step in meeting the legislative mandate requiring an evaluation of the effectiveness of the SOMB's *Standards and Guidelines* (referenced in detail below). Evaluating the effectiveness of any program or system first requires establishing whether the program/system is actually implemented as intended and, if so, the extent to which there may be gaps in full implementation. A *process evaluation* examines the question of implementation and necessarily precedes an outcome or effectiveness study.

The second step in meeting the legislative mandate is to conduct an *outcome evaluation.* Such a study would investigate the effectiveness of the *Standards and Guidelines* by examining whether there is a link between the behavior of offenders subject to the *Standards and Guidelines* and the delivery of services to those offenders. This step will be undertaken in the next 18-24 months, as grant funding allows.

The General Assembly, in C.R.S. 16-11.7-103(4)(d)(I) and (II), directed the SOMB to accomplish the following and report its findings on December 1, 2003:

> *The board shall research and analyze the effectiveness of the evaluation, identification, and treatment procedures and programs developed pursuant to this article. The board shall also develop and prescribe a system…for tracking offenders who have been subjected to evaluation, identification, and treatment*

> *pursuant to this article…. In addition, the board shall develop a system for monitoring offender behaviors and offender adherence to prescribed behavioral changes. The results of such tracking and behavioral monitoring shall be a part of any analysis made pursuant to this paragraph.*

Pursuant to C.R.S. 16-11.7-103(4)(d)(I) and (II), this study was undertaken on behalf of the SOMB by the Division of Criminal Justice (DCJ), Office of Research and Statistics (ORS). The study was funded by Byrne Memorial Fund grant number D22BD19502 from DCJ's Office of Drug Control and System Improvement Program (DCSIP). Data for the study were collected between January 2002 and September 2003.

Organization of this Report

The remainder of this **Introduction Section** provides an overview of best practices for the treatment and management of sex offenders. **Section Two** describes the research methods used in the study, and **Section Three** will describe the case management approach specified in the *Standards and Guidelines.* Following this description, the research findings will be presented in the order for which they appear in the July 2002 edition of the *Standards and Guidelines*. **Section Four** displays all the findings from the process evaluation. **Section Five** highlights the barriers to implementation of the *Standards and Guidelines* as stated by interview respondents. **Section Six** provides recommendations to the SOMB for improving the implementation of existing standards and for modifying the current set of adult *Standards and Guidelines*. The recommendations are based on the data collected and analyzed for this study, pursuant to C.R.S. 16-11.7-103(4)(d)(I) and (II). **Section Seven** presents information on tracking sex offenders.

What are Best Practices?

The set of best practices prescribed by the SOMB is founded on the containment approach, first described by researchers from the Colorado Division of Criminal Justice (DCJ). In 1992, and again in 1997, DCJ's Office of Research and Statistics successfully competed for research grants from the National Institute of Justice, the research section of the U.S. Department of Justice, to study the management of convicted adult sex offenders nationwide (English, Pullen and Jones, 1996; English, 1998; English, Jones, Patrick, Pasini-Hill, 2000; 2003). The relevance of this research activity is that it was undertaken at the same time as the drafting of the first version of the *Standards and Guidelines.* SOMB members were updated regularly on innovative and promising practices (and barriers) implemented elsewhere in the country. The research findings were incorporated into the work of the SOMB, along with information from other studies of adult sex offenders. Research on sex offenders undertaken at DCJ and the Colorado Department of Corrections (CDOC) continues to inform the SOMB and its committees. Relevant

research conducted by others studying sex offender management and related topics also inform the SOMB.
Further, the *Standards and Guidelines* are firmly based on the clinical and agency experience of the experts representing the multiple disciplines and various criminal justice sectors who serve as members of the SOMB. Committee members who may not be Board members but who share their time and expertise in specific topic areas also have made substantial contributions to the *Standards and Guidelines*. Professionals who attend the monthly SOMB meetings and discuss their concerns and experiences have provided essential information, particularly in terms of barriers to full implementation of the SOMB's prescribed approach.

The *Standards and Guidelines* require a coordinated, multi-disciplinary and public safety oriented strategy to risk management that combines comprehensive sex offender treatment and carefully structured criminal justice supervision. It applies to sex offenders serving sentences in the community as well as in prison. The roles and responsibilities of treatment providers, mental health evaluators, polygraph examiners, and supervising officers are specified in the *Standards and Guidelines*.

Offenders on probation and parole, and those in prison, may receive services only from treatment providers, evaluators and polygraph examiners who have submitted comprehensive application materials to the SOMB and, following review by the SOMB's Application Review Committee, are placed on the list of SOMB-approved providers. Once approved, these professionals must reapply to the SOMB every three years.

Training and continuing education requirements for treatment providers, mental health evaluators, and polygraph examiners who offer services to this offender population are specified in the *Standards and Guidelines*. The emphasis on developing professional expertise combined with descriptions of required practices represent the SOMB's attempt to guarantee that mandated sex offender services be of high quality and similarly delivered across the state. Requiring ongoing collaboration among the treatment provider, supervising officer and polygraph examiner ensures that all case information would be shared, risk would be evaluated on an ongoing basis, and the offender would receive clear and consistent information and direction. This approach is designed to give the offender maximum opportunity to change while enhancing public safety through individualized risk management.

In sum, the *Standards and Guidelines* were originally developed in tandem with research on sex offender management conducted at DCJ (English, Pullen and Jones, 1996). Additional research by DCJ's ORS and the Colorado Department of Corrections' Planning and Analysis Unit in collaboration with the Sex Offender Treatment and Monitoring Program (SOTMP), along with findings from other studies in the field, continue to provide the SOMB with information about issues of concern in the management of sex offenders. The value of the clinical experience of the many professionals who participate in the SOMB's cannot be underestimated and this expertise provides necessary direction when research is lacking or implementation is challenging.

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SECTION TWO: RESEARCH DESIGN

Measuring Effectiveness

The first step in measuring the effectiveness of the *Standards and Guidelines* is determining the extent to which they are implemented in the field. The effectiveness of the *Standards and Guidelines* rests on professionals collaborating as required, collecting and sharing risk information on offenders, and consistently applying the protocols described by the SOMB.

One method of measuring implementation is to observe the actual delivery of services by approved providers and specially trained supervising officers. However, this is expensive and resource limitations precluded this approach. Instead, nearly 200 90-minute interviews were conducted with treatment providers, supervising officers, and polygraph examiners. Also, data were hand-collected from the electronic chronological records and paper files of supervising officers and the treatment providers delivering services to 60 offenders who had been placed under supervision in the community in the last few years and had been in treatment for at least six months. Also, collecting and analyzing data from multiple sources enhances the validity of the research findings.

Were all of the *Standards and Guidelines* studied?

Researchers met with members of the SOMB to identify which of the *Standards and Guidelines* were of the greatest concern or importance. See Appendix A for a detailed list and descriptions of the *Standards and Guidelines* selected for study. The file review focused on the presence of documentation that would provide objective information about implementation of specific *Standards and Guidelines*. The interview questionnaires were designed to address both perceptions and beliefs regarding implementation of very specific requirements (e.g. "Does the offender sign a waiver of confidentiality form?") and broader concerns (e.g. "Who is part of the offender management team?" and "Have the *Standards and Guidelines* been useful/detrimental in your work?"). Additional issues, such as whether respondents felt included in the process of developing the *Standards and Guidelines* and questions about the barriers to implementation were also included to shed light on the implementation process.

Data Collection

Telephone Interviews

Attempts were made to include information from *all* individuals who were on the approved treatment provider lists and all probation and parole officers whose responsibilities included the supervision of adult sex offenders. Sixty to 90 minute telephone interviews were conducted with 64 of 127 (50%) of the approved treatment providers and evaluators, 81 probation officers, 29 parole officers (100% of those

supervising sex offenders), and all 17 approved polygraph examiners. The interview questionnaires are included in Appendix B.

The interview questionnaire was pre-tested on therapists and supervising officers who volunteered to work with the ORS researchers to identify problems with the instrument. A final instrument was developed after incorporating information learned during the pretest. Interviewers underwent two days of training in both interviewing skills as well as on the specific instruments to ensure accuracy and consistency in data collection.

File Reviews

Determining the extent to which the *Standards and Guidelines* are implemented required examining documentation in the files that would reflect adherence to the practices required. Presumably the files would be equally consistent in documentation since that is a primary objective of statewide-standardized practice.

To obtain data on how the case was managed in the community, cases need to be under supervision for at least six months. To ensure that the findings would reflect current practices, the supervision period had to be recent. This narrowed the population from which the sample would be identified.

To qualify for entry into the sample, a case was defined as a person who had a current or past conviction for a sex crime, or a conviction for which the underlying factual basis was a sex crime. Once cases were identified, researchers abstracted data from the case files maintained by each offender's treatment provider and supervising officer. In most instances, cases were selected from jurisdictions with at least two sex offenders under supervision. Two researchers were sent to each site to maximize reliability of the data collection.[1]

The data collection instruments ranged in length from 18 (for the treatment file) to 20 pages (for the supervising officer file) and took researchers, on average, 2 to 4 hours to complete. These instruments are included in Appendix C. This review, combined with the time required to set up the logistics to locate valid cases and access the active files, and travel to locations across the state, was extremely time intensive.

Probation. From a list of approximately 663 sex offenders from 63 counties,[2] researchers originally randomly selected 55 probationers. The status of each case was then determined using a computer on the CICJIS premises and then calling the supervising officer to verify the information. From this case review, researchers found many of the cases had been revoked and re-sentenced (some to jail, DOC, or community corrections),

[1] A minimum of two researchers traveled to most sites so that anomalies in the file could be discussed and decisions about scoring procedures would be made by more than one person.

[2] The list of cases was obtained using the Colorado Integrated Criminal Justice Information System (CICJIS) that allowed access to Judicial's ICON database maintained in the RS 6000. Cases charged with a sex crime and meeting the time criteria were identified as the population from which the sample would be selected.

deported, absconded, or were on interstate compact. After this review, only one-third of the cases remained (18 of the original 55) in the sample. For each non-qualifying case, a replacement was selected and the process was repeated.

Once in the field, researchers learned that some cases were not under supervision during the specified period, or were charged but not convicted of a sex crime and, most importantly, were not in sex offender treatment. These cases were also replaced. The final sample included 45 offenders from 14 counties who had been on probation for at least six months between September, 2000 and February 2002. The 45 cases represent between 10-20%[3] of eligible cases that met the sampling criteria.

Ninety (45 supervising officers and 45 treatment provider) case files pertaining to these 45 offenders were reviewed for compliance with the *Standards and Guidelines*.[4] Polygraph examination reports in these files were examined in detail for compliance with the *Standards and Guidelines.* Data were collected on probation cases before the parole sample was identified.

Parole. Efforts to identify and track parolees from the six state parole regions were more complicated. Initially 45 parolees were randomly selected from a list of 89 parolees obtained from the Department of Corrections Planning and Analysis Unit. From this list, offenders with S-Codes of 3[5] were excluded. Further attrition occurred because at least one region did not have a DOC- approved treatment provider. In addition, several parolees absconded, were revoked and returned to prison, discharged their sentence, or were released to a detainer issued by another jurisdiction (including INS detainers). Again, the cases needed to be under active supervision at the time of the data collection to ensure access to all the necessary information.

Unfortunately, the data collection process for parolees was interrupted. The data collection was delayed and eventually terminated when the state assistant attorney general clarified that the treatment files were protected following the April 2003 enactment of the federal Health Insurance Portability Protection Act (HIPAA). This Act requires the signed informed consent of offenders whose cases were selected for this study. Many of the offenders signed consent forms, but some were unable (they were in jail or recently absconded) or unwilling to sign. These complications, combined with time and resource limitations, resulted in a final sample size of only 15 parolees for whom 9

[3] The exact proportion of cases cannot be determined because the status of cases changed over the several months during which the data collection occurred. It was important to review active cases for two reasons: (1) to obtain complete information on documentation of current cases, and (2) to ensure that the data were recent.

[4] Files were reviewed on probationers under supervision in the following counties: Adams, Alamosa, Arapahoe, Archuleta, Boulder, Denver, Douglas, El Paso, Fremont, Jefferson, Larimer, Morgan, Pueblo and Weld.

[5] Upon entry at the Denver Reception & Diagnostic Center inmates receive a code based on their criminal history on the following sexual violence scale. The S-code determines whether the inmate will be recommended for sex offense specific treatment. S-5 is past or current conviction of sex crime, S-4 is history of sexual assault or deviance for which they have not been convicted of S-3 is documented sexual assault in prison.

treatment files were available for analysis. This resulted in a combined total of 24 treatment and parole files (including polygraph examination reports) were reviewed on site by DCJ researchers.[6]

The final case file review in the field resulted in data from 45 probationers and 15 parolees totaling 60 sex offenders and 114 files (60 officer files and 54[7] treatment provider files) including 214 polygraph examination reports.

The sample is not representative of any single jurisdiction. The sample was designed to reflect general practices statewide. The *Standards and Guidelines* are intended to promote communication and consistency across and within jurisdictions, so this sample provides an important depiction of actual practices by the three key members of the containment team.

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[6] Parolees in the sample were under supervision in the following counties or cities: Arapahoe, Westminster, Denver, Pueblo, Canon City, Greeley, Ft. Collins, and Colorado Springs.
[7] The HIPAA requirement interfered with the collection of data from six treatment files.

SECTION THREE: COLORADO'S SEX OFFENDER TREATMENT, MONITORING AND CONTAINMENT SYSTEM

Brief Overview

The *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* apply to adult sexual offenders under the jurisdiction of the criminal justice system in Colorado. The SOMB's enabling legislation recognized that the criminal sexual behaviors of many offenders can be managed, much like high blood pressure can be managed, but there is no known "cure" for the problem. The *Standards and Guidelines* are based on best practices and, where possible, current research pertaining to the treatment and management of sex offenders.

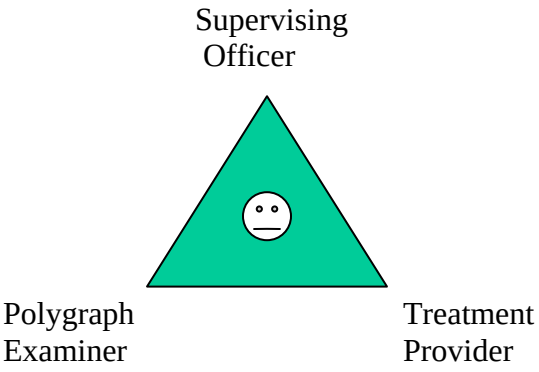
The *Standards and Guidelines* are described in a document that is over 100 pages in length, and issues are clarified and expanded in over 50 pages of appendices. The document reflects the careful thinking of a multi-disciplinary group and is founded on 13 guiding principles:

1. Sexual offending is a behavioral disorder that cannot be "cured."
2. Sex offenders are dangerous.
3. Community safety is paramount
4. Assessment and evaluation of sex offenders is an on-going process. Progress in treatment and level of risk are not constant over time.
5. Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors.
6. Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management purposes.
7. Victims have a right to safety and self-determination.
8. When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests.
9. A continuum of sex offender management and treatment options should be available in each community in the state.
10. Standards and guidelines for assessment, evaluation, treatment and behavioral monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.
11. The management of sex offenders requires a coordinated team response.
12. Sex offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, bound by the rules of ethics and law.

13. Successful treatment and management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in the sex offenders' lives.

These principles are operationalized in the *Standards and Guidelines* document. Work is underway to update the current version of the adult *Standards and Guidelines* and to include information obtained from the study findings presented here.

The *Standards and Guidelines* state that sex offenders should not be in the community without comprehensive treatment, supervision and behavioral monitoring. Treatment, supervision and monitoring reflect multi-disciplinary activities undertaken by professionals with expertise in very specific areas. The treatment provider, supervising officer and polygraph examiner comprise the basic containment team.



According to the *Standards and Guidelines*, additional members of the containment team may include the unit supervisor, other probation or parole officers, social workers/case workers, law enforcement, special population therapists (substance abuse counselor, for example), employers, and members of the offender's support system.

At the core of this management system is the intent that the offender be held consistently accountable for his or her behavior. An underlying philosophy in Colorado's containment system is placing the responsibility on the offender to demonstrate progress in treatment and risk reduction.

Sex offense-specific treatment is a comprehensive set of planned therapeutic experiences and interventions intended to provide offenders with the tools to change sexually abusive thoughts and behaviors. When treatment is encouraged by agents of the criminal justice system (the courts and the parole board), offenders are motivated to actively engage in therapy. In a recent study by DCJ of the Department of Correction's sex offender therapeutic community, the longer an offender spent in very intense treatment the more likely the offender remained arrest free in the years following release from prison. In fact, those who remained arrest free logged, on average, at least 30 months in the intense prison program.[8]

[8] Lowden et al., July 2003.

Under the *Standards and Guidelines*, probation and parole officers are to receive special training in the risk management of sex offenders and reinforce treatment assignments and behavioral expectations along with providing careful monitoring of the individual behavior patterns of specific offenders. Specially trained polygraph examiners are to work closely with treatment providers and supervising officers to track offenders and to verify risk and behaviors reflecting compliance with supervision and treatment mandates. Additional management tools include law enforcement registration, individual treatment plans that may include important information obtained from victims' therapists, treatment contracts and written conditions of supervision, leisure time monitoring, home and employment visits, clearly specified restrictions pertaining to internet use and locations where victims may be accessed.

The supervision team works together to obtain each offender's "modus operandi" and supervision, treatment and polygraph examinations are structured to interrupt the offense pattern *before* a new sex crime is committed. This is the essence of risk management and offender containment as envisioned by the SOMB and operationalized in the *Standards and Guidelines.*

Standards are denoted by the word "shall" while guidelines are referenced with the word "should."

Limitations of this Research

This study is a process evaluation. It was conducted to determine the extent to which the *Standards and Guidelines* are actually implemented in the field. Without information about implementation and services delivered, outcome findings—including recidivism studies—cannot be linked to services provided. Outcome data were not collected and analyzed in this study.

The response rate for the telephone interviews with therapists was only 50%. Unfortunately, there is no way of knowing if the perceptions and beliefs of those who did not participate in the telephone survey differs from those who did.

Relying on information documented in files to reflect implementation assumes that all relevant case management decisions and activities are documented. This is unlikely to be the case. The extent to which the absence of documentation reflected a lack of adherence to the *Standards and Guidelines* or a lack of documentation remains unknown.

Sixty sex offenders were randomly selected from a pool of several hundred probationers and parolees under supervision in the community. These cases were identified so that probation/parole and treatment files relating to the offender could be examined for documentation reflecting adherence to the *Standards and Guidelines.* Specific criteria were used to identify cases for study. The criteria were intended to ensure access to the most complete and recent case management information. Researchers estimate that between 10% and 20% of qualifying cases were studied, but not all areas of the state had qualifying cases available for study. The sample is not intended to be representative of

any single jurisdiction. Rather, the sample was designed to reflect general practices statewide. Any sampling of files--large or small--would presumably reflect all files since compliance with the *Standards and Guidelines* is expected statewide.

SECTION FOUR: FINDINGS FROM THE PROCESS EVALUATION

1.000 GUIDELINES FOR PRE-SENTENCE INVESTIGATIONS

SUMMARY OF FINDINGS:

***This Guideline appears to be implemented as planned*. The Pre-Sentence Investigation Report (PSIR) was found in the probation and parole files over 85% of the time, reflecting strong adherence to this guideline. Further, the content of the 60 PSIRs examined revealed excellent coverage of criminal history information and substance abuse issues. Likewise, education history and family/marital history were adequately addressed most of the time. Nearly 80% of the probation files and two-thirds (9) of the parole files adequately addressed employment. The file review also found that financial status and residential situation was adequately addressed for 40-65% of the PSIRs.**

However, content areas in 20 to 30 of the 60 PSIRs that appeared to be minimally addressed, or not discussed at all, included the following:

- **Leisure/recreation activities**
- **Companions**
- **Attitude at time of interview**
- **Victim impact, and**
- **Victim grooming behaviors**

Data supporting these findings are presented below.

1.010 Each sex offender should be the subject of a pre-sentence investigation, including a mental health sex offense-specific evaluation, prior to sentencing, even when by statute it is otherwise acceptable to waive the pre-sentence investigation.

Table 1: Pre-Sentence Investigation Reports (PSIR) Found in the Files

	Probation Officer Files n=45	Parole Officer Files n=15
No	13.3% (6)	6.7% (1)
Yes	86.7% (39)	93.3% (14)

1.040 A pre-sentence investigation (PSI) report should address the following:

Criminal history
Education/employment
Financial status
Assaultiveness
Residence
Leisure/recreation
Companions
Alcohol/drug problems
Victim impact
Emotional/personal problems
Attitude/orientation
Family, marital and relationship issues
Offense patterns and victim grooming behaviors
Mental health sex offense-specific evaluation report
The potential impact of each sentencing option on the victim(s)

Table 2: Information Addressed in the Pre-Sentence Investigation Reports (PSIR)

	Probation Officer Files **n=39***	**Parole Officer Files** **n=14***
Criminal history		
*Addressed Adequately***	100% (39)	100% (14)
Education history		
Addressed Adequately	84.6% (33)	78.6% (11)
Employment history		
Addressed Adequately	79.5% (31)	64.3% (9)
Financial status		
Addressed Adequately	59% (23)	50% (7)
Residence		
Addressed Adequately	66.7% (26)	42.9% (6)
Leisure/recreation activities		
Addressed Adequately	23.1% (9)	21.4% (3)
Companions		
Addressed Adequately	23.1% (9)	35.7% (5)
Drug /alcohol problems		
Addressed Adequately	87.2% (34)	78.6% (11)
Victim impact addressed		
Addressed Adequately	38.5% (15)	35.7% (5)
Emotional and personal problems		
Addressed Adequately	56.4% (22)	35.7% (5)

Attitude at time of interview and during process		
Addressed Adequately	41% (16)	35.7% (5)
Family, marital and relationship		
Addressed Adequately	74.4% (29)	71.4% (10)
Offense/assault patterns		
Addressed Adequately	59% (23)	64.3% (9)
Victim grooming behaviors		
Addressed Adequately	20.5% (8)	35.7% (5)
The potential impact of each sentencing option on the victim(s)		
Addressed Adequately	25.6% (10)	14.3% (2)
Additional information: Criminal orientation		
Addressed Adequately	46.2% (18)	64.3% (9)

*The number of files containing PSIRs.

**The term "addressed adequately" means that there was a sufficient level of descriptive information for a decision maker to assess the appropriateness of community placement and level of supervision.

2.000
STANDARDS FOR MENTAL HEALTH SEX OFFENSE-SPECIFIC EVALUATIONS

SUMMARY OF FINDINGS:

***As intended by the* Standards and Guidelines*, the 45 Mental Health Sex Offense-Specific Evaluations (MHSOSE) examined by researchers were found to be comprehensive and thorough, but copies of the evaluations were not always present in professionals' files.* Most of the time (83.3%), the MHSOSE was found in the treatment provider files and it was found in nearly all of the probation officer files. However, researchers found the MHSOSEs in only 4 of the 15 parole officer files examined. Since the Colorado Department of Corrections (DOC) maintains multiple files on offenders, it is possible that the MHSOSE was located in another file; researchers only examined parole officers' "active" files.**

In the 45 treatment provider files that included the MHSOSE, researchers found the use of 51 different assessment tools and procedures. The most commonly used instruments were the Millon Clinical Multiaxial Inventory (73% of files) and the Multiphasic Sex Inventory (58%). Table 4 includes a list of the most commonly used instruments. Most of the 45 evaluations reviewed by researchers included recommendations for offense-specific treatment; the *Standards* require that the level and intensity of offense-specific treatment be recommended by the evaluator. The 45 evaluations addressed the issue of community placement in only 15 (29%) although the *Standards* require the evaluator to recommend the appropriateness of community placement.

Data supporting these findings are presented below.

2.010 In accordance with Section 16-11-102(1)(b) C.R.S., each sex offender shall receive a mental health sex offense-specific evaluation at the time of the pre-sentence investigation.

Table 3: Mental Health Sex Offense-Specific Evaluation Found in the Files

	Probation Officer Files n=45	Parole Officer Files n=15	Treatment Provider Files n=54
No	4.4% (2)	73.35 (11)	16.7% (9)
Yes	95.6% (43)	26.7% (4)	83.3% (45)

2.060 Because of the uncertainty of risk prediction for sex offenders, the Board recommends the following approaches to evaluation:

Use of instruments that have specific relevance to evaluating sex offenders
Use of instruments with demonstrated reliability and validity
Integration of collateral information
Use of multiple assessment instruments and techniques
Use of structured interviews
Use of interviewers who have been trained to collect data in a non-pejorative manner

AND

2.070 Unless otherwise indicated below, the following evaluation modalities are all required in performing a mental health sex offense-specific evaluation:

Examination of criminal justice information, including the details of the current offense and documents that describe victim trauma, when available
Examination of collateral information, including information from other sources on the offender's sexual behavior
Structured clinical and sexual history and interview
Offense-specific psychological testing
Standardized psychological testing if clinically indicated
Medical examination/referral for assessment of pharmacological needs if clinically indicated
Testing of deviant arousal or interest through the use of the penile plethysmograph or the Abel Screen

Table 4: Most Commonly Used Instruments for the Mental Health Sex Offense-Specific Evaluation

Instruments Used	Frequency of Use n=45
• Structured Interview	95.6% (43)
• Collateral Information	86.7% (39)
• MCMI-II or III	73.3% (33)
• MSI (Multiphasic Sex Inventory)	57.8% (26)
• Shipley Institute Of Living Scale	51.1% (23)
• Plethysomograph • Abel	44.4% (20)*
• Wilson Sexual Fantasy Questionnaire	37.8% (17)
• MMPI or MMPI 2 • STATIC 99	35.6% (16)*
• HARE	31.1% (4)*

• SONE • Abel And Becker Cognition • SONAR	
• Beck Depression Scale • RRASOR	28.9% (13)*
• Abel And Becker Card Sort • SVP Instrument (Includes The DCJ Risk Assessment)	20% (9)*

*Multiple tests grouped in this table reflect the number (frequency) of evaluations that included all of these in the tests.

2.090 A mental health sex offense-specific evaluation of a sex offender shall consider the following:

Sexual evaluation, including sexual developmental history and evaluation for sexual arousal/ interest, deviance and paraphilias
Character pathology
Level of deception and/or denial
Mental and/or organic disorders
Drug/alcohol use
Stability of functioning
Self-esteem and ego-strength
Medical/neurological/pharmacological needs
Level of violence and coercion
Motivation and amenability for treatment
Escalation of high-risk behaviors
Risk of re-offense
Treatment and supervision needs
Impact on the victim, when possible

Table 5: Areas Addressed and Considered to be Problem from the Mental Health Sex Offense-Specific Evaluation

Evaluation Area	Addressed in Treatment Provider Files n=45	Determined to be a Problem for the Offender n varies
EVALUATE MENTAL AND/OR ORGANIC DISORDERS		
IQ Functioning *(Mental retardation, learning disability, and literacy)*	86.7% (39)	10.3% (4)
Organic Brain Syndrome *(OBS)*	46.7% (21)	0
Mental Illness *(DSM-IV diagnosis or other clearly stated disorder)*	95.6% (43)	39.5% (17)

EVALUATE DRUG/ALCOHOL USE*		
Alcohol and Drug Use/Abuse	97.8% (44)	34.1% (15)
EVALUATE CHARACTER PATHOLOGY		
Degree of Impairment	86.7% (39)	41% (16)
EVALUATE STABILITY OF FUNCTIONING		
Marital/Family Stability *(Past, current, familial violence familial sexual, financial housing)*	95.6% (43)	31.8% (14)
Employment/Education *(completion of major life tasks)*	95.6% (43)	11.6% (5)
Social Skills *Aability to form and maintain relationships, courtship/dating skills, ability to demonstrate assertive behavior)*	82.2% (37)	50% (19)
DEVELOPMENTAL HISTORY		
Disruptions in parent/child relationship *History of bed wetting, cruelty to animals* *History of behavior problems in elementary school,* *History of special education services, learning disabilities, school achievement* *Indicators of disordered attachments*	80% (36)	18.4% (7)
EVALUATION OF SELF		
Self-image, Self Esteem, Ego Strength	84.4% (38)	53.8% (21)
MEDICAL SCREENING MEASURES		
Pharmacological Needs *Medical condition impacting offending behavior* *History of medication use/abuse*	77.8% (35)	11.1% (4)
SEXUAL EVALUATION		
Sexual History *(onset, intensity, duration, pleasure derived)* *Age of onset of expected normal behaviors* *Quality of first sexual experience* *Age of onset of sexually deviant behaviors* *Witnessed or experienced victimization as a child (sexual or physical)* *Genesis of sexual information* *Age/degree of use of pornography, phone sex, cable, video, or internet for sexual purposes* *Current and past range of sexual behavior*	97.8% (44)	100% (44)
Reinforcement Structure for deviant behavior *Culture, environment, cults*	37.8% (17)	21.1% (4)

Arousal Pattern *Sexual arousal, sexual interest*	88.6% (39)	43.9% (18)
Specifics of Sexual Crime(s) *(Onset, intensity, duration, pleasure derived)* *Detailed description of sexual assault* *Seriousness, harm to victim* *Mood during assault (anger, erotic, "love")* *Progression of sexual crimes* *Thoughts preceding and following crimes* *Fantasies preceding and following crimes*	93.3% (42)	97.6% (41)
Sexual Deviance	97.8% (44)	38.6% (17)
Dysfunction *(Impotence, priapism, injuries, medications affecting sexual functioning, etc.)*	40% (18)	11.1% (2)
Offender's Perception of Sexual Dysfunction	31.1% (14)	21.4% (3)
Preferences *(Male/female; age; masturbation targets; use of tools, utensils, food, clothing; current sexual practices, deviant as well as normal behaviors)*	88.9% (40)	38.5% (15)
Attitude/Cognition *Motivation to change/continue behavior* *Attitudes toward women, children sexuality in general* *Attitudes about offense (i.e., seriousness, harm to victim)* *Degree of victim empathy* *Presence/degree of minimalization* *Presence/degree of denial* *Ego-syntonic v s. ego-dystonic sense of deviant behavior*	82.2% (37)	54.1% (20)
Attitudes About Offense *(i.e., seriousness, harm to victim)* *Degree of victim empathy* *Presence/degree of minimization* *Presence/degree of denial* *Ego-syntonic v s. ego-dystonic sense of deviant behavior*	95.6% (43)	74.4% (32)
EVALUATE LEVEL OF DENIAL AND/OR DECEPTION		
Level of denial *Level of deception*	93.3% (42)	61.9% (26)
EVALUATE LEVEL OF VIOLENCE AND COERCION		
Level of violence, pattern of assaults, victim selection, escalation of violence	64.4% (29)	27.6% (8)
EVALUATE RISK		
Risk of re-offense	86.7% (39)	59% (23)

2.110 The evaluator shall recommend:

The level and intensity of offense-specific treatment needs
Referral for medical/pharmacological treatment if indicated
Treatment of co-existing conditions
The level and intensity of behavioral monitoring needed
The types of external controls which should be considered specifically for that offender (e.g. controls of work environment, leisure time, or transportation; life stresses, or other issues that might increase risk and require increased supervision)
Methods to lessen victim impact
Appropriateness and extent of community placement.

Upon request, the evaluator (if different from the treatment provider) shall also provide information to the case management team or prison treatment provider at the beginning of an offender's term of supervision or incarceration.

Table 6: Recommendations in the Mental Health Sex Offense-Specific Evaluation

Recommendations	Frequency Topic Found in the Treatment Provider Files n=45
Offense–Specific Treatment	78.8% (41)
Referral For Medical Or Pharmacological Treatment	19.2% (10)
Treatment Of Coexisting Problems	32.7% (17)
Appropriate External Controls	11.5% (6)
Appropriateness Of Community Placement	28.8% (15)
Additional Information	
No Contact With Children	32.7% (17)
No Contact With Defendant's Children	5.8% (3)

3.000
STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

SUMMARY OF FINDINGS:

Sex offense-specific treatment is a core component of the management of sex offenders and, as such, this *Standard* addresses a myriad of topics. According to the data collected from a limited number of case files and from interviews with 50% of the treatment providers, *the requirements specified in this* Standard *were generally met. It appears from the data collected for this study that treatment was indeed a significant intervention in the lives of sex offenders under supervision in the community.* Documents in the files showed that, in general, treatment providers informed offenders in writing of their expectations, including issues pertaining to restricted contact with victims, potential victims and children. Offenders were participating in group and individual treatment, and efforts by treatment providers to manage situational risk factors were common and usually documented with safety plans. Treatment progress was generally well recorded as were issues of offender denial. Nearly all treatment providers reported during interviews that they frequently work with family members of convicted offenders, an activity listed in the *Standards:* "Actively involve relevant family and support system.

The *Standards* would be more fully implemented if all treatment plans were individualized and included goals with measurable objectives along with a plan to achieve those objectives. Also, copies of relapse prevention plans were available in only 6 of the 54 treatment files reviewed. Therapist and supervising officers could ensure further compliance with the *Standards* if they provided complete and consistent documentation of rule violations and the response to that violation, and if the information in their files included more details about progress in treatment. Complete documentation of case management is required to study the impact and "analyze the effectiveness" of the *Standards and Guidelines* per C.R.S. 16.11.7-103(d)(I).

More detailed findings from this summary are bulleted below. The bulleted findings are followed by presentation of the data analyzed to assess the implementation of *Standard 3.0.*

The findings below discuss the following topics: sex-offense specific treatment, confidentiality waivers, individualized treatment contracts, relapse prevention plans, the management of offenders in denial, and the use of assessment and behavioral monitoring tools.

- ***Treatment Plans.*** Most (79.8%; 51 of 64) therapists said that their treatment plans are individualized but also contained standard "boilerplate" language. However,

of the 42 treatment plans found in the treatment provider files, 16 were not individualized as required by the SOMB. Three files had no treatment plan.

Nearly all (98.4%; 63 of 64) of the therapists interviewed said they addressed contact with children in their treatment plans, reflecting the importance of this issue. Yet, researchers reviewing plans found that not all (61.9%; 26 of 42) of the plans addressed this topic.

About 40% of the treatment plans did not include clear, measurable objectives and a plan to achieve those objectives, as required by the *Standards*. The areas to be addressed in the treatment plans are described in Table 13.

- ***Waivers of confidentiality.*** The file reviews indicated that most treatment providers documented the requirement that offenders waive confidentiality so that information can be shared with the supervising officer, polygraph examiner, and others as determined necessary by the therapist.

- ***Service Delivery.*** According to data obtained from 54 treatment provider files, offenders were participating in a variety of treatment services including both group therapy and individual sessions (types of services delivered according to file reviews are listed in Appendix D). Treatment contracts specified the type and frequency of treatment, and most identified how the duration of treatment would be determined. Most contracts also specified behavioral restrictions and referenced the conditions of supervision, including the requirement to participate in polygraph testing. Treatment files documented offenders' attendance and, in varying degrees of detail, progress in the program although rule violations and failed assignments were documented less consistently. Most (90%) of the treatment providers reported that they included in their work the spouses and family members in some form; over one-third had worked in some manner with offenders' children and half reported involvement with adult family members, including parents, siblings, in-laws and cousins.

- ***Relapse Prevention Plans.*** Although nearly all (90%) of the therapists interviewed said they addressed relapse prevention, only 11.1% of treatment provider files, and even fewer officer files, contained an RP plan (not all data presented). It was quite likely that offenders maintained "work-in-progress" plans as part of their homework material, however it would be valuable for therapist files to include photocopies of a recent version of the plan. Many of the therapists' files contained safety plans for specific events, however, indicating efforts to manage situational risk factors. A list of such events can be found in Appendix E.

- ***Offenders In Denial. Nearly three-fourths*** (77.7%; 42 out of 54) of the treatment provider files had some notation of offender denial and defensiveness; most often it was assessed in the mental health sex offense-specific evaluation report. Half (30 of 60) of the probation and parole files reviewed found offenders to be in

some level of denial at the start of the supervision process. Six months later it appeared that only nine remained in some level of denial, suggesting that most offenders had worked or were working through this issue while under supervision. (Only one of the nine cases was returned to court on a revocation and for this case supervision was continued.)

- ***Sanctions and Consequences.*** Sanctions and consequences included more intensive treatment, more homework, lectures by supervising officers or therapists, requirements to address their denial in group, and prohibitions from extra curricular activities and other restrictions. The types of monitoring ranged from an increase in the frequency of appointments with their supervising officer to daily call-ins and electronic monitoring. It is not clear from the data collected how frequently the polygraph may have been used to assist offenders through denial. See Appendix F for more details.

- ***Assessment and Behavioral Monitoring.*** Nearly half (25) of the 54 treatment files reviewed reflected the use of a plethysmograph for sexual arousal assessment, and 32 reflected the use of the Abel Screen to assess sexual interests. Most therapists reported during interviews that they used polygraph information in-group treatment, to focus treatment, to assess risk and monitor treatment compliance. Deceptive polygraph findings resulted in a variety of restrictions, as specified in Table 28. Out of the 64 therapists interviewed 81.3% (52) of them responded that they sanctioned or imposed consequences when an offender had deceptive polygraph results. Nearly 74% (45) of treatment providers said they sometimes imposed sanctions/consequences on offenders who have inconclusive polygraph results. Inconclusive findings can result from an offender's lack of cooperation, but there may be other reasons as well.

3.100 ♦ Sex Offense-Specific Treatment

3.110 Sex offense-specific treatment must be provided by a treatment provider registered at the full operating level or the associate level under these standards.

All the treatment providers interviewed as well as collected from were SOMB approved providers.

3.130 A provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender.

The treatment plan shall:

Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender
Be individualized to meet the unique needs of the offender
Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment

Define expectations of the offender, his/her family (when possible), and support systems
Address the issue of ongoing victim input

Table 7: Treatment Plans Found in Treatment Provider Files

	Treatment Provider Files n=54
No	22.2% (12)
Yes	77.8% (42)

Table 8: Language Contained in Treatment Plans

	Documentation in Treatment Provider Files n=42*	Treatment Provider Telephone Responses n=64
Individual	21.4% (9)	15.6% (10)
Standard language	40.5% (17)	4.7% (3)
Contains both individual and standard language	**	79.7% (51)
Not individualized	38.1% (16)	**

*There were only 42 treatment plans found in the treatment provider files.
**Response not offered by this group.

Table 9: Treatment Provider Telephone Responses to Areas Addressed in the Treatment Plans

n=64*	Contact with Children**	Victim Input**	Impact on Victim**	Relapse Prevention**
No	1.6% (1)	54.7% (35)	31.3% (20)	4.7% (3)
Yes	98.4% (63)	45.3% (29)	67.2% (43)	90.6% (58)
Additional Comments from those who said YES				
	No contact clearly stated (42)	If available, discussed in treatment plan (8)	Victim empathy is part of treatment (27)	Relapse prevention is part of treatment (48)
	Requirements to have contact are listed (15)	Clarification addressed (4)		Relapse prevention addressed in group (5)
	If offender wants contact, included as a goal (5)	Victim representative input included (4)		

*The "yes" and "no" answers do not total 64 when the information from the remaining interviews was missing on that particular question.
**Other areas that identified during the interviews that are addressed in the treatment plans were social skills, medical/pharmacological needs, substance abuse, relationships, trauma and anger. The areas in the table were most commonly mentioned as key components of the treatment plan.

Table 10: Treatment Plans Found in Treatment Provider Files Address the Following Areas n=42

Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender	
No	26.2% (11)
*Yes, specifically and thoroughly**	11.9% (5)
*Yes, although somewhat vague**	61.9% (26)
Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment	
No	9.5% (4)
*Yes, specifically and thoroughly**	31% (13)
*Yes, although somewhat vague**	59.5% (25)
Define expectations of the offender, his/her family (when possible), and support systems	
No	26.2% (11)
*Yes, specifically and thoroughly**	31% (13)
*Yes, although somewhat vague**	42.9% (18)
Address the issue of ongoing victim input	
No	81% (34)
*Yes, specifically and thoroughly**	4.8% (2)
*Yes, although somewhat vague**	14.3% (6)

*Researchers judged whether there was a sufficient level of descriptive information to guide another professional in directing treatment and assessing offender progress.

3.140 A provider shall employ treatment methods that are supported by current professional research and practice:

A Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of psychological treatment used must conform to the standards for content of treatment (see F., below) and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and shall be avoided except when geographical--specifically rural--or disability limitations dictate its use.

Table 11: Types of Services Documented in the Treatment Provider Files

Treatment Services Received*
• Group Therapy • Individual Therapy • Anger Management • Drug and Alcohol Treatment • Couples Therapy • Family Sessions • Victim Empathy

*A complete list of treatment services can be found in Appendix D.

F The content of offense-specific treatment for sex offenders shall be designed to:

14. Require offenders to develop a written relapse prevention plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses;

Table 12: Relapse Prevention Plans Found in Treatment Provider Files

	Treatment Provider Files n=54
No	88.9% (48)
Yes	3.7% (2)
Relapse prevention plan appears to be in progress	7.4% (4)

3.150 Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Colorado state law on health care records. Client files shall:

A Document the goals of treatment, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations and consequences given should be recorded.

AND

B Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.

Table 13: Treatment Plan Documentation

Documentation of Goals of Treatment and Methods Used From Treatment Provider Files n=42*	
All goals have objectives and methods.	59.5% (25)
Some but less than half of the goals have objectives and methods.	9.5% (4)
There are no objectives and methods to meet the goals.	14.3% (6)
No individual goals are listed. Offender must pass through a specified program.	16.7% (7)

*Treatment plans were found in 42 of 54 files.

Table 14: Progress in Treatment: Presence and Frequency of Documentation

	Documentation of the Following Areas in the Last Six Months of Treatment n=54	Of those with documentation, Three or More References of Documentation n varies
Specific achievements	48.1% (26)	57.5% (15)
Failed assignments	48.1% (26)	53.8% (14)
Rule violations	75.9% (41)	41.5% (17)
Treatment progress	98.1% (53)	84.9% (45)
Lack of treatment progress	83.3% (45)	55.6% (25)
Attendance	100% (54)	90.7% (49)

3.200 ♦ Confidentiality

3.210 A treatment provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality should extend to the victim's therapist. The waiver of confidentiality shall extend to the supervising officer and all members of the team (see 5.100) and, if applicable, to the Department of Human Services and other individuals or agencies responsible for the supervision of the offender.

Table 15: Signed Waivers of Confidentiality Found in Treatment Provider Files

	Treatment Provider Files n=54
No	18.8% (10)
Yes	81.5% (44)

Table 16: Treatment Contract Addresses Confidentiality Waivers

	Treatment Provider Files n=49*
No	8.2 % (4)
Yes	91.8% (45)

*49 treatment contracts were found in 54 provider files.

3.300 ♦ Treatment Provider-Client Contract

3.310 A provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of treatment. The contract shall define the specific responsibilities of both the provider and the client.

A The contract shall explain the responsibility of a provider to:

1. Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;

2. Describe the waivers of confidentiality which will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;

3. Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;

4. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined, and;

5. Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.

Table 17: Documentation from the Treatment Provider Files Regarding Content of the Treatment Contract

The Treatment Contract Shall Explain the Responsibility of a Provider to:	n=49*
Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations	79.6% (39)
Describe the waivers of confidentiality which will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver	91.8% (45)**
Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;	42.9% (21)
Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined, and;	87.8% (43)
Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.	67.3% (33)

*49 treatment contracts were found in the 54 files reviewed by researchers.
**Sometimes the issue of non-confidentiality was included in the treatment contract and these waivers were often found as stand-alone forms requiring the offender's signature.

B The contact shall explain any responsibilities of a client (as applicable) to:

1. Pay for the cost of assessment and treatment for him or herself, and his or her family, if applicable;

2. Pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;

3. Inform the client's family and support system of details of past offenses, which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;

4. Actively involve relevant family and support system, as indicated in the relapse prevention plan.

Table 18: Telephone Responses from Treatment Providers about Working with Offender Family Members

	Treatment Provider Telephone Responses n=62*
No	3.1% (2)
Yes	93.8% (60)

*Not everyone responded.

Table 19: Treatment Provider Telephone Responses About Which Family Members They Work With

n=64	Spouses	Children	Adult Relatives (parents, siblings, aunt/uncles, cousins, in-laws)
Male	48.3% (29)	31.7% (19)	53.3% (32)
Females	95.0% (57)	36.7% (22)	

* Therapists also mentioned working with partners or significant others, friends and neighbors, chaperones, employers and ministers.

5. Notify the treatment provider of any changes or events in the lives of the client and members of the client's family or support system;

6. Participate in polygraph testing as required in the Standards and Guidelines and, if indicated, plethysmographic testing as adjuncts to treatment;

7. Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;

8. Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client.

Table 20: Details of Treatment Contract

The Treatment Contact Shall Explain Any Responsibilities of a Client (as applicable) to:	n=49
Pay for the cost of assessment and treatment for him or herself, and his or her family, if a pplicable;	91.8% (45)
Pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;	63.3% (31)
Inform the client's family and support system of details of past offenses, which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;	77.6% (38)
Actively involve relevant family and support system, as indicated in the relapse prevention plan.	67.3% (33)
Notify the treatment provider of any changes or events in the lives of the client and members of the client's family or support system;	59.2% (29)
Participate in polygraph testing as required in the Standards and Guidelines and, if indicated, plethysmographic testing as adjuncts to treatment;	89.8% (44)
Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;	67.3% (33)
Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client.	75.5% (37)

C The contact shall also, (as applicable):

1. Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;

2. Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;

3. Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;

4. Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff, and;

5. Describe limitations or prohibitions on employment or recreation.

Table 21: More About the Treatment Contract

The Treatment Contact Shall Also (as applicable):	n=49
Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;	91.8% (45)
Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;	89.8% (44)
Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;	79.6% (39)
Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff, and;	87.8% (43)
Describe limitations or prohibitions on employment or recreation.	65.3% (32)

3.600 ♦Community Placements and Treatment of Sex Offenders in Denial

3.620 Level of denial and defensiveness shall be assessed during the mental health sex offense-specific evaluation.

Table 22: Level of Denial Assessed During The Mental Health Sex Offense-Specific Evaluation?

	Treatment Provider Files n=45*
No	4.4% (2)
Yes	93.3% (42)
Can't determine	2.2% (1)

*45 mental health sex offense-specific evaluations were found in 54 treatment provider files.

3.630 When a sex offender in strong or severe denial must be in the community (e.g. on mandatory parole), offense-specific treatment shall begin with an initial module that specifically addresses denial and defensiveness. Such offense-specific treatment for denial shall not exceed six months and is regarded as preparatory for the remaining course of offense-specific treatment.

Table 23: Documenting Denial Process

At the Start of Treatment was the Offender in Denial?*			
	Probation Officer Files **n=45**	**Parole Officers Files** **n=15**	**Treatment Provider Files** **n=54**
No	42.2% (19)	6.7% (1)	29.6% (16)
Yes	46.7% (21)	60.0% (9)	53.7% (29)
Can't determine*	11.1% (5)	33.3% (5)	16.7% (9)

* Denial was most likely to be addressed when it was an issue for the offender.

If YES…

Table 24: Documentation Regarding Treatment for Denial

Was the Offender Offered Treatment to Address Denial?			
	Probation Officer Files **n=21**	**Parole Officers Files** **n=9**	**Treatment Provider Files** **n=29**
No	19% (4)	33.3% (3)	13.8% (4)
Yes	33.3% (7)	33.3% (3)	20.7% (6)
Can't determine*	47.6% (10)	33.3% (3)	65.5% (19)

* Denial was most likely to be addressed when it was an issue for the offender.

3.650 Offenders who are still in strong or severe denial and/or are strongly resistant after this six (6) month phase of treatment shall be terminated from treatment and revocation proceedings should be initiated if possible. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if revocation is not an option. In no case should a sex offender in continuing denial of the facts of the offense remain indefinitely in offense-specific treatment.

Table 25: Denial Six Months Later: Documentation

After Six Months in Treatment was the Offender in Denial?			
	Probation Officer Files **n=26**	**Parole Officers Files** **n=14**	**Treatment Provider Files** **n=38**
No	26.9% (7)	13.3% (2)	28.9% (11)
Yes	26.9% (7)	13.3% (2)	13.2% (5)
Can't Determine*	46.2% (12)	66.7% (10)	57.9% (22)

* Denial is most likely mentioned when it is or has been an issue for the offender.

3.700 ♦ Treatment Providers' Use of the Polygraph and Plethysmograph and Abel Screen

3.720 It is recommended that a provider employ plethysmography as a means of gaining information regarding the sexual arousal patterns of sex offenders or the Abel screen as a means of gaining information regarding the sexual interest patterns of sex offenders.

Table 26: Use of Plethysmograph and Abel Screen

	Plethysmograph **n=54**	**Abel Screen** **n=54**
No	46.3% (25)	37% (20)
Yes	46.3% (25)	59.3% (32)
Can't determine	7.4% (4)	3.7% (2)

3.740 The case management team shall determine the frequency of polygraph examinations, and the results shall be reviewed by the team. The results of such polygraphs shall be used to identify treatment issues and for behavioral monitoring.

Table 27: Open-ended Question to Therapists: How do you use the polygraph results?

Therapist Telephone Survey Responses to How They Use the Polygraph Results: Open-ended Question **n=64**	
52.5% (32)	• Confront the offender in group, discuss results with offender.
41% (25)	• Meet with/call supervising officer and discuss. Review to determine areas of concern/risk to help focus treatment. Team reviews results, staff inconclusive results, decipher polygraphs.
24.6% (15)	• Monitor compliance/progress, monitor contact, use as a monitoring tool.
18% (11)	• Sanction offender by using the DOC sanction grid, restrictions, and increase homework.
9.8% (6)	• Use as a reinforcement or consequence; use as a treatment tool; focus on the polygraph in treatment.
8.2% (5)	• To increase benefits and privileges. Reward/praise offender. • Gauge progress.
3.4% (4)	• To make treatment plan changes.

Table 28: Open-ended Question to Therapists: What sanctions or consequences are imposed for deceptive results?

Ten Most Common Responses from Therapists Regarding the Types of Sanctions or Consequences Imposed for *Deceptive* Polygraph Results n=64	
1. Increase treatment, extra groups (i.e. failed polygraph group), individual sessions, daily contact with treatment provider, study hall	66.1% (39)
2. Increase restrictions (i.e. travel, curfew, etc)	47.5% (28)
3. Given more homework (i.e. journal, written clarification)	42.4% (25)
4. Retake or more frequent polygraph exams	28.8% (17)
5. Loss of privileges	23.7% (14)
6. Increase supervision, monitoring, or containment	18.6% (11)
7. Use sanction grid	15.3% (9)
8. Electronic home monitoring (EHM), Global Positioning System (GPS)	13.6% (8)
9. House arrest	13.6% (8)
10. Weekend in jail	6.8% (4)

Table 29: Open-ended Question to Therapists: What sanctions or consequences are imposed for inconclusive results?

Ten Most Common Responses from Therapists about the Types of Sanctions or Consequences Imposed for *Inconclusive* Polygraph Results n=64	
1. Increase treatment, extra groups (i.e. failed polygraph group), individual sessions, daily contact with treatment provider, study hall	34.1% (15)
2. Retake or more frequent polygraph exams	50% (22)
3. Given more homework (i.e. journal, written clarification)	22.7% (10)
4. Consider it a failed polygraph	22.7% (10)
5. Loss of privileges	9.1% (4)
6. Electronic home monitoring (EHM), Global Positioning System (GPS)	4.5% (2)
7. Weekend in jail	4.5% (2)
8. House arrest	4.5% (2)
9. Self-pay for polygraphs	2.3% (1)
10. Remove offender from home if reunited with family	2.3% (1)

Additional uses of polygraph information mentioned by therapists included: changing the offender's living situation or job, increasing the use of other monitoring methods such as urinalysis testing, prohibit contact with kids.

5.000
STANDARDS AND GUIDELINES FOR MANAGEMENT OF SEX OFFENDERS ON PROBATION, PAROLE AND COMMUNITY CORRECTIONS

SUMMARY OF FINDINGS:

This section of the *Standards and Guidelines* addresses specific expectations for supervision teams. Treatment providers, supervising officers and polygraph examiners are provided direction in terms of communication, training, supervision conditions and issues of non-compliance. *With few exceptions, this comprehensive set of requirements appeared to be implemented by the majority of these professionals, reflecting a commitment to the team approach to managing risk.*

Supervising officers, polygraph examiners and treatment providers, in nearly unanimous agreement, reported in interviews that the interagency community supervision team included the supervising officer and the treatment provider. However, only 60% of the supervising officers and treatment providers considered polygraph examiners part of the containment team while nearly all of the examiners considered themselves team members. Although, about 60% of polygraph examiners reported talking to treatment providers and 70% said they talk to supervising officers at least monthly, over half reported that the amount of contact remained inadequate. Recent (within the last six months) verbal contact between the supervising officer and the treatment provider was documented in over 90% of the probation files (one probationer was discussed on 22 occasions); contact was documented in 60% of the parole files but these contacts were rarely recorded in the treatment provider files.

Teamwork is a core component of sex offender management since shared information is used to develop individualized containment strategies. Researchers asked interviewees about the extent to which conflict, which as the potential of interrupting communication, was experienced among the professionals and if so how it was resolved. Two-thirds of the supervising officers said conflict sometimes occurred; 75% said the conflict was due to differences in opinions and approaches, although nearly 20% said that conflict emerged when the therapist advocated for the offender instead of community safety. Methods to resolve conflict were described by over 80% of supervising officers and 70% of treatment providers, including compromising, talking it through and using help from a third party (data not presented).

Of some concern was a finding that one-fourth of supervising officers and about one-half of therapists reported that they talked to the polygraph examiner *before* the exam, although two-thirds of both groups said, in response to a different question, they always or almost always provide input into the question content for the exam. It is important to remember that the examiner can construct the most germane

questions when completely informed about an offender's recent progress in treatment. A focused exam provides more accurate information, and this is important since 90% of supervising officers said they always or sometimes impose consequences for deceptive polygraph results.

Documented progress reports from the treatment provider to the supervising officer are an important part of the communication process necessary to manage risk in the community. Nearly three-fourths (77.3%) of officers said they received monthly progress reports from treatment providers. A review of progress reports found probation and parole officer files contained monthly progress reports for only 60% of cases. Nine therapists said they did not provide monthly progress reports despite the requirement to do so.

Overall, the data from this study reflect a significant exchange of information by team members about offenders. This communication is commonly but not always documented in the files; improved recording of case activities in the files will enhance future research efforts to link specific aspects of team collaboration to client outcome.

Data supporting this summary is presented below.

5.100 ♦ Establishment of an Interagency Community Supervision Team

5.120 Each team at a minimum, should consist of:

the supervising officer
the offender's treatment provider and
the polygraph examiner[9]

Each team is formed around a particular offender and is flexible enough to include any individuals necessary to ensure the best approach to managing and treating the offender. Team membership may therefore change over time.

The team may include individuals who need to be involved at a particular stage of management or treatment (e.g., the victim's therapist or victim advocate). When the sexual offense is incest, the child protection worker is also a team member if the case is still open.

[9] Please see Standard 5.420 regarding the attendance of polygraph examiners at team meetings.

Table 30: Multiple Responses from Open-ended Questions: Who is Typically Part of the Interagency Community Supervision Team?

	Supervising Officer Responses n=110	Treatment Provider Responses n=64	Polygraph Examiner Reponses n=17
Supervising officer	*	100% (63)	100% (17)
Treatment provider	93.6% (103)	*	100% (17)
Polygraph examiner	60.0% (66)	60.3% (38)	82.4% (14)
Other:			
Social workers/caseworkers	10.4% (5)	14.7% (6)	*
Victim Advocate/therapist	9.1% (10)	24.6% (15)	*
Co-therapists	*	92.7% (38)	*
Psychiatrist, or other mental health professionals	18.8% (9)	2.4% (1)	*
Families, friends, support system, chaperone	18.8% (9)	7.3% (3)	*
Unit Supervisor/team leader	43.8% (21)	*	*
Other probation or parole officers	33.3% (16)	2.4% (1)	*
All therapists in the office; treatment staff	*	92.7% (38)	*

*Response not offered by this group.

Table 31: Open-ended, Multiple Responses about the Advantages to a Team Approach

Advantages	Supervising Officer Telephone Responses n=110	Treatment Provider Telephone Responses n=64
Shared perspective, different expertise, better understand offender	81.7% (85)	48.4% (31)
Backup; not doing it alone	*	46.9% (30)
Blending of ideas, better input, better information exchange	23.1% (24)	31.2% (20)
Prevents manipulation by offender	39.4% (41)	26.6% (17)
Increases community safety	14.4% (15)	*

*Response not offered by this group.

Table 32: Open-ended, Multiple Responses about the Disadvantages to a Team Approach

Disadvantages	Supervising Officer Telephone Responses n=110	Treatment Provider Telephone Responses n=64
None	*	21.9% (14)
Time issues, large caseloads, slows decision-making process	31.3 (21)	29.7% (19)
Disagreement on risk level; treatment too lenient	13.4% (9)	32.8% (21)
Differing opinions; used to working alone	38.8% (26)	*
Communication can be difficult	19.4% (13)	*
Location; can't choose treatment providers; frustration with PO	10.7% (7)	9.4% (6)

*Response not offered by this group.

5.150 The team should demonstrate the following behavioral norms:

A There is an ongoing, completely open flow of information among all members of the team;

B Each team member participates fully in the management of each offender;

C Team members settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response. The final authority rests with the supervising officer;

Table 33: Telephone Responses about Teams Experiencing Conflict

	Supervising Officer Telephone Responses n=109*	Treatment Provider Telephone Responses n=64
No, the teams they work with do not experience conflict	33.9% (37)	25% (16)
Yes, the teams they work with do experience conflict	55% (60)	75% (48)
Sometimes, some do and some don't experience conflict	11% (12)	**

*The answers do not total 65 when the information from the remaining interviews was missing on that particular question.
**Response not offered by this group.

5.160 Team members should communicate frequently enough to manage and treat sexual offenders effectively, with community safety as the highest priority.

Table 34: Treatment Provider Contact with *Probation Officers*

Treatment Providers Talking to *Probation Officers*	
n=64	
Between daily and weekly	59.4% (38)
More than monthly but less than weekly	25% (16)
Monthly	12.5% (8)
Every couple of months	1.6% (1)
Specific situations	1.6% (1)
Treatment Provider Response: Is frequency of contact with *probation officer* adequate?	
n=64	
No	4.7% (3)
Yes	81.3% (52)
Somewhat	12.5% (8)

Table 35: Treatment Provider Contact with *Parole Officers*

Treatment Providers Contact with *Parole Officers*	
n=28*	
Between daily and weekly	9.4% (6)
More than monthly but less than weekly	12.5% (8)
Monthly	14.1% (9)
Every couple of months	4.7% (3)
Specific situations	3.1% (2)
Treatment Provider Responses: Is frequency of contact with *parole officer* adequate?	
n=30*	
No	13.3% (4)
Yes	60.0% (18)
Somewhat	26.6% (8)

* Fewer than half of the treatment providers worked with parolees.

Treatment Provider Responses for the Reasons They Contact *Supervising Officers*	
n=64	
Discuss disclosures of abusive behavior	42.7% (47)
New disclosures of past victims	31.8% (35)
To discuss payment for services	24.5% (27)
Discuss result of polygraph exam	27.3% (30)
When offender is danger to self or others	20.9% (23)
Employment issues	7.3% (8)
Housing issues	7.3% (8)

Table 36: Supervising Officer Contact with *Treatment Providers*

Supervising Officers Contact with *Treatment Providers*	
n=110	
Between daily and weekly	47.3% (53)
More than monthly but less than weekly	26.8% (30)
Monthly	14.3% (16)
Specific situations	5.4% (6)
Varies	4.5% (5)
Supervising Officer Responses: Is frequency of contact with *treatment providers* adequate?	
n=109	
No	6.4% (7)
Yes	81.7% (89)
Somewhat	11.9% (13)
Supervising Officer Responses for the Reasons They Contact *Treatment Providers*	
n=110	
To discuss specific incidents	50.9% (56)
To discuss disclosures	30.0% (33)
Talk about the polygraph	21.8% (24)
To check in, get information	28.2% (31)
To report contact with victim/potential victims	24.5% (27)
To discuss offender out-of-state travel plans	17.3% (19)
Regarding violations/revocations	19.1% (21)

Table 37: Polygraph Examiner Contact with *Supervising Officers*

Polygraph Examiners Contact with *Supervising Officers*	
n=17	
Between daily and weekly	29.4% (5)
More than monthly but less than weekly	11.8% (2)
Monthly	17.6% (3)
Specific situations	23.5% (4)
Varies	17.6% (3)
Polygraph Examiner Responses: Is frequency of contact with *supervising officer* adequate?	
n=17	
No	58.8% (10)
Yes	17.6% (3)
Somewhat	23.5% (4)
Polygraph Examiner Responses for the Reasons They Contact *Supervising Officers*	
n=17	
Discuss new disclosures of information	88.2% (15)
That the offender was not prepared for the polygraph	11.8% (2)
Discuss the results of the polygraph exam	23.5% (4)
To report behaviors encountered during the exam	29.4% (5)
To schedule a polygraph	17.6% (3)
To discuss payment for the examination	11.8 (2)

Table 38: Additional Contact Information

Treatment Provider Talking to *Polygraph Examiner*	
n=64	
Between daily and weekly	14.1% (9)
More than monthly but less than weekly	12.5% (8)
Monthly	3.1% (2)
Every couple of months	3.1% (2)
Specific situations	37.5% (24)
Varies	25% (16)
Never	4.7% (3)

Polygraph Examiner Responses: Is frequency of contact with *treatment providers* adequate? n=17	
No	52.9% (9)
Yes	23.5% (4)
Somewhat	23.5% (4)
Polygraph Examiner Responses for the Reasons They Contact *Treatment Providers* n=17	
Discuss new disclosures of information	76.5% (13)
That the offender was not prepared for the polygraph	100% (17)
Discuss the results of the polygraph exam	76.5% (13)
To report behaviors encountered during the exam	47.1% (8)
To schedule a polygraph	35.3% (6)
To discuss payment for the examination	100% (17)

Table 39: Documentation in Officer Files that the Team Convened in Person, by Phone or Email

	Probation Officer Files n=45	Parole Officer Files n=15
Team Convened In Person		
No	93.3% (42)	93.3% (14)
Yes	2.2% (1)	0
Can't determine if there is a team	4.4% (2)	6.7% (1)
Team Convened by Phone or Email		
No	93.3% (42)	93.3% (14)
Yes	2.2% (1)	0

Table 40: Documentation from the Files that Officer Discussed the Offender with Therapist or Examiner, during a Six Month Time Period

	Probation Officer Files n=45		Parole Officer Files n=15	
	Treatment Provider	***Polygraph Examiner***	***Treatment Provider***	***Polygraph Examiner***
No	4.4% (2)	77.8% (35)	33.3% (5)	93.3% (14)
Yes	91.1% (41)	15.6% (7)	60.0% (9)	0
Can't determine	4.4% (2)	6.7% (3)	6.7% (1)	6.7% (1)
Average number of times discussed offender in the last 6 months	4.95	1.14	1.89	0

Table 41: Circumstances for When Supervising Officers Talk to Polygraph Examiners About Offenders on Their Caseloads

Most Common Responses from Supervising Officers about When they Talk to Polygraph Examiners	
1. After the exam (i.e. discuss results)	75.5%
2. Prior to the exam (i.e. schedule an exam)	52.9%
3. Problems/issues/concerns arise	34%

Table 42: Circumstances for When Treatment Providers Talk to Polygraph Examiners About Offenders on Their Caseloads

Most Common Responses from Treatment Providers about When they Talk to Polygraph Examiners	
1. Prior to the exam (i.e. schedule an exam)	68.5%
2. After the exam (i.e. discuss results)	22.9%
3. Before and after the exam	14.3%

5.200 ♦ Responsibilities of the Supervising Officer for Team Management

5.230 The supervising officer, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions.

Table 43: Telephone Survey Responses to Providing Input into the Question Content for the Polygraph Exam

	Supervising Officer Telephone Responses n=108*	Treatment Provider Telephone Responses n=64
Never or Seldom	4.6% (5)	4.7% (3)
Always or Almost Always	63.9% (69)	25% (16)
Sometimes	31.5% (34)	70.3% (45)

*Not everyone responded to this question.

Table 44: Supervising Officer Responses about Imposing Consequences for Polygraph Results

	Deceptive Polygraph Results n=109*
No	8.3% (9)
Yes	76.1% (83)
Depends/Sometimes	13.8% (15)
Don't know	1.8% (2)

*Not everyone responded to this question.

5.240 The supervising officer should require sex offenders to provide a copy of the written plan developed in treatment for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising officer should utilize the relapse prevention plan in monitoring offenders' behavior.

Table 45: Relapse Prevention Plans in Supervising Officer Files

	Probation Officer Files n=45	Parole Officer Files n=15
No	88.9% (40)	100% (15)
Yes	2.2% (1)	0
Incomplete relapse plan	8.9% (4)	0

5.270 The supervising officer should require treatment providers to keep monthly written updates on sex offenders' status and progress in treatment.

Table 46: Supervising Officer Telephone Responses about Receiving Monthly Progress Reports

	Supervising Officers Responses About Receiving Written Progress Reports from the Treatment Provider n=105*
Receive them monthly	77.3% (85)
Sometimes receive written reports	7.3% (8)
Depends on the treatment provider	10.9% (12)

*Not everyone responded to this question.

Table 47: Open-ended Telephone Responses about the Types of Information Received in Progress Reports

	Supervising Officer Telephone Responses n=110	Treatment Provider Telephone Responses n=64
Attendance	66.4% (73)	60.9% (39)
Participation	64.5% (71)	54.7% (35)
Polygraph results	50.9% (56)	43.8% (28)
General information	40.9% (45)	23.4% (15)
Treatment compliance	33.6% (37)	35.9% (23)
Changes in risk level	20.9% (23)	29.7% (19)

Table 48: Evidence of Monthly Progress Reports in Supervising Officer Files

	Probation Officer Files n=45	Parole Officer Files n=15
No	11.1% (5)	26.7% (4)
Yes	57.8 (26)	60% (9)
Some, but not monthly	31.1% (14)	13.3% (2)

IF SOME, BUT NOT MONTHLY…

Table 49: Number of Times Found in the Supervising Officer Files

	Probation Officer Files n=45	Parole Officer Files n=15
2 times	2	*
3 times	3	1
4 times	5	*
5 times	4	1

* Response not given by this group.

5.280 The supervising officer should discuss with the treatment provider, the victim's therapist, custodial parent or foster parent, and guardian ad litem specific plans for any and all contacts of an offender with a child victim and plans for family reunification.

Table 50: Telephone Responses from Team Members about Discussing Plans for Offender's Contact with Child Victim and Plans for Family Reunification

	Discuss Plans for Contact with Children	Discuss Family Reunification
Supervising officers contact treatment providers too…	14.5% (16)	6.4% (7)
Treatment providers contact supervising officers too…	18.8% (12)	30.7% (20)

5.216 The supervising officer should notify sex offenders that they must register with local law enforcement, in compliance with Section 18-3-412.5 C.R.S.

Table 51: Notification of Sex Offender Registration in Supervising Officer Files

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	0
Yes	88.9% (40)	93.3% (14)
Not applicable	8.9% (4)	6.7% (1)

5.222 Supervising officers assessing or supervising sex offenders should successfully complete training programs specific to sex offenders.

Table 52: Multiples Responses from Supervising Officer Telephone Surveys about the Types of Trainings Officers Receive

Source of Trainings n=110	
Seminars, SOMB, COMCOR, judicial etc.	74.5% (83)
80-hour advanced training, introduction or overview to sex offenders	40.6% (43)
Special topics including lifetime supervision, the Abel, PPG, victim impact, etc.	17% (18)

Table 53: Supervising Officer Telephone Responses about when they Receive Training

When They Received the Training n=110	
Before they started supervising sex offenders	36% (40)
Right when they began supervising sex offenders	1% (1)
After they began supervising sex offenders	59% (65)
Have not received training yet	3% (3)
Can't remember	1% (1)

5.223 On an annual basis, supervising officers should obtain continuing education/training specific to sex offenders.

Table 54: Supervising Officer Telephone Responses about Receiving Additional Training/Continuing Training

Receiving Additional Training/Continuing Education n=110	
Receive additional training	92% (101)
Do not receive additional training	7% (8)
Have been on the job less than a year	1% (1)

Table 55: Supervising Officer: Frequency of Additional Training/Continuing Education

Frequency of Additional Training/Continuing Education n=100*	
Once or twice a month	16.3% (18)
Three to six times a year	21.8% (24)
Annually, twice a year, 20-40 hours annually	34.6% (38)
Bi-annually	11.8% (13)
Rarely, when offered, once in a while	6.3% (7)

*Not everyone responded.

Table 56: Additional Types of Training Mentioned

Some Additional Training Supervising Officers Have Attended
• Training on the polygraph and sanctions • CASCI • PPG training • ABEL training • GPS training • ATSA training • Probation training • In house/treatment provider training • Training on legal issues, and • Changes in legislation

5.300 ♦ Responsibilities of the Treatment Provider within the Team

5.310 A treatment provider shall establish a cooperative professional relationship with the supervising officer of each offender and with other relevant supervising agencies.

Table 57: Telephone Survey Responses from Treatment Providers about Working with Multiple Supervising Officers

Treatment Provider Responses to the Number of Supervising Officers They Work with n=64					
	1-5	**6-10**	**11-15**	**16+**	**Average**
Probation Officers	44.8% (28)	33.5% (21)	11% (7)	11% (7)	8.14
Parole Officers	60.8% (28)	4.7% (3)	0	0	2.22

B A provider shall immediately report to the supervising officer evidence or likelihood of an offender's increased risk of re-offending so that behavioral monitoring activities may be increased.

Table 58: Multiple Responses from Supervising Officers about Reasons for Contact with Treatment Providers

Supervising Officers Report that Treatment Providers Contact Them for the Following Reasons n=110	
Discuss disclosures of abusive behavior	42.7% (47)
New disclosures of past victims	31.8% (35)
To discuss payment for services	24.5% (27)
Discuss result of polygraph exam	27.3% (30)
When offender is danger to self or others	20.9% (23)
Employment issues	7.3% (8)
Housing issues	7.3% (8)

5.400 ♦ Responsibilities of the Polygraph Examiner within the Team

5.410 The polygraph examiner shall participate as a member of the post-conviction case management team established for each sex offender.

Table 59: Polygraph Examiner Phone Survey Responses To Being Considered Part of Interagency Community Supervision Team

	Polygraph Examiner Telephone Responses n=17
No	11.8% (2)
Yes	82.4% (14)
Sometimes	5.9% (1)

5.420 The polygraph examiner shall submit written reports to each member of the community supervision team for each polygraph exam as required in section 6.190. Reports shall be submitted in a timely manner, no longer than two (2) weeks post testing.

Table 60: Telephone Survey Reponses about Receiving Copies of Polygraph Reports from Polygraph Examiners

	Supervising Officer Telephone Responses n=108*	Treatment Provider Telephone Responses n=63*
Always or almost always	95.4%(103)	95.3% (61)
More than half the time	3.7% (4)	1.6% (1)
Less than half the time	0.9% (1)	**
Never or seldom	**	3.1% (2)

*Not everyone responded.
**Response not offered by this group.

Table 61: Copies of Polygraph Reports Found in Files

	Supervising Officer Files n=54	Treatment Provider Files n=54
No	3.7% (2)	5.6% (3)
Yes	94.4% (51)	92.6% (50)
Not applicable (i.e. offender did not show up for polygraph exam)	1.9% (1)	1.9% (1)

5.500 ♦ Conditions of Community Supervision

5.510 In addition to general conditions imposed on all offenders under community supervision, the supervising agency should impose the following special conditions on sex offenders under community supervision:

A Sex offenders shall have no contact with their victim(s), including correspondence, telephone contact, or communication through third parties except under circumstances approved in advance and in writing by the supervising officer in consultation with the community supervision team. Sex offenders shall not enter onto the premises, travel past, or loiter near the victim's residence, place of employment, or other places frequented by the victim.

Table 62: Evidence in the Files that the Offender can have No Contact with their Victims

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	97.8% (44)	93.3% (14)

B Sex offenders shall have no contact, nor reside with children under the age of 18, including their own children, unless approved in advance and in writing by the supervising officer in consultation with the community supervision team. The sex offender must report all incidental contact with children to the treatment provider and the supervising officer, as required by the team.

Table 63: Evidence in the Files that the Offender is Prohibited Contact with Children Under Age 18

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	0
Yes	97.8% (44)	100% (15)

C Sex offenders who have perpetrated against children shall not date or befriend anyone who has children under the age of 18, unless approved in advance and in writing by the supervising officer in consultation with the community supervision team.

Table 64: Evidence in the Files that the Offender may not Date, Befriend, or Marry Anyone who has Children Under Age 18

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	93.3% (42)	93.3% (14)
Can't determine	4.4% (2)	0

D Sex offenders shall not access or loiter near school yards, parks, arcades, playgrounds, amusement parks, or other places used primarily by children unless approved in advance and in writing by the supervising officer in consultation with the community supervision team.

Table 65: Evidence in the Files that the Offender is Prohibited in Places Primarily Used by Children

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	91.1% (41)	93.3% (14)
Can't determine	4.4% (2)	0

E Sex offenders shall not be employed in or participate in any volunteer activity that involves contact with children, except under circumstances approved in advance and in writing by the supervising officer in consultation with the community supervision team.

Table 66: Evidence in the Files of Employment or Volunteering Restrictions

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	93.3% (42)	93.3% (14)
Can't determine	4.4% (2)	0

F Sex offenders shall not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, computer programs or services.

Table 67: Evidence in the Files that the Offender is Prohibited from Possessing Pornographic or Sexually Stimulating Materials

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	95.6% (43)	93.3% (14)
Can't determine	2.2% (1)	0

G Sex offenders shall not consume or possess alcohol.

Table 68: Evidence in the Files that the Offender has been Notified that they Shall Not Consume or Possess and Drugs or Alcohol

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	0
Yes	95.6% (43)	100% (15)
Can't determine	2.2% (1)	0

H The residence and living situation of sex offender must be approved in advance by the supervising officer in consultation with the community supervision team.

Table 69: Evidence in the Files that the Offender's Residence Must Be Approved in Advance

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	0
Yes	95.6% (43)	100% (15)
Can't determine	2.2% (1)	0

I Sex offenders will be required to undergo blood, saliva, and DNA testing as required by statute;

Table 70: Evidence in the Files that the Offender has been Notified that they will be Required to Undergo a Blood, Saliva, and DNA test

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	95.6% (43)	86.7% (13)
Not applicable	2.2% (1)	6.7% (1)

J Other special conditions that restrict sex offenders from high-risk situations and limit access to potential victims may be imposed by the supervising officer in consultation with the community supervision team;

Table 71: Evidence in the Files that the offender is restricted from High-Risk Situations and Potential Victims

	Probation Officer Files n=45	Parole Officer Files n=15
No	17.8% (8)	40% (6)
Yes	80% (36)	60% (9)
Can't determine	2.2% (1)	0

K Sex offenders shall sign information releases to allow all professionals involved in assessment, treatment, and behavioral monitoring and compliance of the sex offender to communicate and share documentation with each other;

Table 72: Evidence in the Files that the Offender signed Releases of Information

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	20% (3)
Yes	97.8% (44)	80% (12)

L Sex offenders shall not hitchhike or pick up hitchhikers.

Table 73: Evidence in the Files that the Offender May Not Hitchhike or Pick Up Hitchhikers

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	93.3% (42)	93.3% (14)
Can't determine	4.4% (2)	0

M Sex offenders shall attend and actively participate in evaluation and treatment approved by the supervising officer and shall not change treatment providers without prior approval of the supervising officer.

Table 74: Evidence in the Files that the Offender will Attend and Actively Participated in Evaluations and Treatment and Not Change Treatment Providers Without Prior Approval

	Probation Officer Files n=45	Parole Officer Files n=15
No	2.2% (1)	6.7% (1)
Yes	95.6% (43)	93.3% (14)
Can't determine	2.2% (1)	0

5.600 ♦ Behavioral Monitoring of Sex Offenders in the Community

5.610 The monitoring of offenders' compliance with treatment and sentencing requirements shall recognize sex offenders' potential to re-offend, to re-victimize, to cause harm, and the limits of sex offenders' self-reports.

Table 75: Number of times officer files document source of information regarding Non-Compliant behavior

Source of Information*	Probation Officer Files n=45	Parole Officer Files n=15
Offender's self report	64	3
Home visits	6	2
Treatment provider	59	23
Disclosure during polygraph exam	63	20
Detection by supervising officer	14	23
Law enforcement	6	1
Third party	10	0
Court: Failure to appear notice	16	0
Other	10	7
Total	248	79

*Files often contained documentation of multiple instances of noncompliance and multiple sources of information.

Table 76: 204 Polygraph Exams Used to Monitor Offenders

Number of Examinations Per Offender n=52*	
1 exam	10
2 exams	5
3 exams	9
4 exams	12
5 exams	7
More than 5 exams	9

*There were 54 files that researchers looked at however; two of the files did not contain any polygraph reports.

Table 77: Type of Polygraph Exams used to Monitor Offenders in the Community

Number of Examination Reports Reviewed by Researchers n=202*	
Disclosure Polygraph Exams	**56**
• *Deceptive polygraph results*	33
Maintenance Polygraph Exams	**113**
• *Deceptive polygraph results*	48
Specific Issue Exams	**33**
• *Deceptive polygraph results*	26
TOTAL EXAMS	**202***

*There were 204 polygraph exams done, however; there were 202 polygraph results because for two offenders their exams were terminated.

Table 78: Open-ended, Multiple Responses from Supervising Officer Telephones Surveys about the Use of the Polygraph Exam Information in Monitoring Offender Behavior

Value or Usefulness	Supervising Officer Telephone Responses n=110
Determine compliance	50% (55)
Gain insight about offender	51.8% (57)
Promotes honesty about behavior	57.3% (63)
For exploring high risk situations/suspicions	44.5% (49)
To address denial	29.1% (32)

Table 79: Telephone Responses from Supervising Officers about Sanctions for Deceptive or Inconclusive Polygraph Results

Sanctions n=110	Deceptive Results	Inconclusive Results
Increase supervision	70.0% (77)	19.4% (14)
Retake the polygraph exam/specific issue exam	37.2% (41)	40.0% (44)
Increase treatment	42.7% (47)	10.9% (12)
Loss of privileges, extend probation, community service	34.5% (38)	n/a*
Treat these the same as failed polygraphs	n/a*	25.5%(28)

*Response not offered for this finding.

B Behavioral monitoring should be increased during times of an offender's increased risk to re-offend, including, but not limited to, such circumstances as the following:

1. The offender is experiencing stress or crisis;

Table 80: Documentation of Offender Experiencing Stress or Crisis in Supervising Officer File

Documentation of stress or crisis in last year?	Probation Files n=45	Parole Files n=15
No	48.9% (22)	46.7% (7)
Yes	51.1% (23)	53.3% (8)

Table 81: Officer Files: Number of Times Documentation Reflected Offenders Experienced Stress/Crisis in the Past 12 Months

Number of Stress Episodes Documented	Probation Files n=45	Parole files n=15
1	39.1% (9)	37.5% (3)
2	26.1% (6)	37.5% (3)
3	8.7% (2)	12.5% (1)
Numerous	26.1% (6)	12.5% (1)

Table 82: Monitoring Responses to the Stress/Crisis Offenders Experienced

Types of Monitoring Responses
▪ Engage in budget planning ▪ Computer checked more often ▪ Evaluation for depression med ▪ Increased supervision ▪ Daily Urine Analysis (UA) ▪ Discussed with probation officer ▪ Moved to an adult community ▪ Have client bring in 3 job applications ▪ Retake polygraph ▪ Increase treatment ▪ Return to Court ▪ Moved to more intensive treatment program ▪ Fined ▪ Disconnected cable TV ▪ Imposed curfew ▪ Issued summons/complaint/revocation

5.700 ♦ Sex Offenders' Contact with Victims and Potential Victims*

SUMMARY OF FINDINGS:

The need to clarify the decision making process regarding an contact with children is underscored in the data presented in this section. **Sixty-three percent (70 of 110) of supervising officers and 76.5% (49 of 64) of treatment providers responded in phone surveys that offenders they currently supervise are permitted contact with children (data not presented). Among treatment providers who work with offenders who have contact with children, most of them (80%) stated that they saw between 1 and 5 offenders who have contact with children. The type of contact varies, from unsupervised and not chaperoned to letters or cards that are first reviewed by a chaperone. Very few offenders had unsupervised physical contact with children. Most of the supervising officers and therapists described additional requirements that are placed on offenders who have contact with children.**

Half (53%) of therapists and nearly half (44%) of the officers reported that the decision to allow contact is made according to compliance with the SOMB's *Standard 5.7* criteria. Among supervising officers, 26 reported that the decision to allow contact with children was made by the judge or the parole board.

Most treatment providers and supervising officers reported that a victim advocate or victim therapist is usually involved in the decision-making process regarding child contact, as required by this *Standard.* However, the review of 60 files found documentation of a victim's therapist or representative in only 10 cases (data not reported).

Unfortunately, documentation pertaining to child contact and collaboration with child victims' therapists is difficult to access. It appears to be buried in the supervising officers' chronological records or polygraph examination reports or not available at all without accessing treatment files. Should the SOMB decide to study the issues surrounding child contact, extracting the data from case files may be problematic.

Table 83: Among Treatment Providers Who Have Offenders With Child Contact On Their Caseloads: How Many Offenders Have Contact?

Treatment Provider Telephone Responses **n=49***	
77.5% (38)	▪ Have between 1-5 offenders who have contact with children on their caseload
6.1% (3)	▪ Have between 6-10 offenders who have contact with children on their caseload
8.2% (4)	▪ Have between 11-15 offenders who have contact with children on their caseload
4.1% (2)	▪ Have between 16-20 offenders who have contact with children on their caseload
4.1% (2)	▪ Have between 20 or more offenders who have contact with children on their caseload

*49 of 64 (76.5%) treatment providers reported working with offenders who had contact with children.

Table 84: Telephone Responses to the Various Ways Offenders Have Contact With Children

Type of contact allowed	Supervising Officer Telephone Responses n=110	Treatment Provider Telephone Responses n=64
No unsupervised visits; visits are monitored by treatment.	34.5% (38)	7.8% (5)
Offender lives with children and has unrestricted contact. Physical contact is okay.	30% (33)	31.5% (17)
Contact with certain children is permitted (i.e. grandchildren); face to face.	16.4% (18)	28.1% (18)
Limited contact only, offender cannot live with children, only incidental contact	14.5% (16)	20.3% (13)
Only phone contact is permitted; unmonitored phone calls.	7.3%% (8)	28.1% (18)
No physical contact is permitted	6.3% (7)	7.8% (5)
Staff must be present, trained supervisor present, approved supervisor/chaperone,	0	21.9% (14)
Letters/cards (through chaperone), phone and letters are approved by therapist	0	18.9% (12)
Family gatherings; holidays; special events; must be in public places; time limited visits; special times, days, places	0	20.3% (13)

Table 85: Telephone Responses About Victim Advocates or Therapists Involvement in Decisions Regarding Offender Contact with Children

	Supervising Officer Telephone Responses n=108*	Treatment Provider Telephone Responses n=52*
No	15.7% (17)	4.7% (3)
Yes	75% (81)	89.1% (57)
Most children do not have a victim advocate or therapist	9.3% (10)	3.1% (2)

*The number of cases varies due to missing data.

Table 86: Supervising Officer Telephone Responses about how these Victim Advocates or Therapists are involved in Child Contact Decisions

Most Common Responses from Supervising Officers about the Victim Advocates or Therapist Involvement
1. Victim advocate or therapist meets with or staffs the case with the supervising officer.
2. Victim advocate or therapist is involved in the oversight of the visit or the clarification process.
3. Victim advocate or therapist completes the evaluation of the victim.
4. Victim advocate or therapist provided general information.
5. Victim advocate or therapist provides written documentation.

Table 87: Treatment Provider Telephone Responses about how these Victim Advocates or Therapists are Involved

Most Common Responses from Treatment Providers about the Victim Advocates or Therapist Involvement
1. Victim advocate or therapist are invited to team meetings and attend staffings.
2. Treatment providers meet with victim advocates or therapists at the start of treatment, talk with advocate, send letter to victim therapist.
3. Treatment providers set up victim clarification sessions with advocate; therapist is involved with clarification plans; helps decide if victim and offender are ready for contact.
4. Victim advocate or therapist represents child's needs/best interest, involved all the way through, acts as a liaison.
5. Victim advocate or therapist has the final word on contact.

Table 88: Documentation in Supervising Officer Files About Collaboration with Others Regarding Possible Communication, Visits, And Family Reunification

Documentation in the File?	Probation Officer Files n=45	Parole Officer Files n=15
No	77.8% (35)	100% (15)
Yes	22.2% (10)	0

5.710 For purposes of compliance with this standard, supervising officers and providers shall:

A Whenever possible, collaborate with an adult victim's therapist or advocate, or a child victim's therapist, guardian, custodial parent, foster parent, and/or guardian ad litem, in making ***decisions*** regarding communication, visits, and reunification.

Table 89: Multiple Responses from Supervising Officers about How the Child Contact Decision is Made

How?	Frequency of Supervising Officer Telephone Responses n=110
Offender met *Standard 5.7* criteria	44.5% (49)
Judge or parole board ordered it	23.6% (26)
Chaperone was approved/significant other is in treatment (5.7 criterion)	11.8% (13)
Contact permitted before officer got the case or before SOMB 5.7 was in place	10.9% (12)
Used assessment instruments	8.2% (9)
Team decided it was okay	7.3% (8)
Offender has strong safety plan (5.7 criterion)	3.6% (4)

Table 90: Multiple Responses from Treatment Providers about How the Child Contact Decision is Made

How?	Frequency of Treatment Provider Telephone Responses n=64
Offender met *Standard 5.7* criteria	53.1% (34)
Offender had non-deceptive polygraphs (5.7 criterion)	31.3% (20)
Court ordered	7.8% (5)
Entire team staffs case to make sure child is not at risk	7.8% (5)
Child was not a victim of offender	15.6% (10)
Offender shows no deviant arousal, can manage deviant sexual impulse (5.7 criterion)	12.5% (8)
No contact was damaging to children; children/victim wanted contact; reunification desired by children and/or spouse	17.2% (11)
Offender shows accountability, proven safety record, minimal thinking errors, understands victim issues (5.7 criteria)	7.8% (5)
Spouse attended informed supervisors group; adequate supervision (5.7 criterion)	4.6% (3)
Supervisor approves the safety plan (5.7 criterion)	4.6% (3)
Clarification letter completed (5.7 criterion)	3.1% (2)
Custodial parent could not handle the pressure;	10.9% (7)*

offender allowed to live at home; offender is in aftercare; offender has terminally ill daughter and is allowed to see her; offender must be in treatment a minimum of 2 years; offender petitions team for contact; PO has final decision	
Child/child advocate consults; get victim therapists input	3.1% (2)

Table 91: Multiple Responses from Supervising Officers Regarding Who Makes Child Contact Decisions

Who Makes the Decision?	Frequency of Supervising Officer Telephone Responses n=110
Probation/parole	12.7% (14)
Treatment and the supervising officer	19.1% (21)
The entire team	60% (66)
The court/judge	5.5% (6)
The treatment provider	5.5% (6)
No one can have contact	4.5% (5)
DOC	2.7% (3)
Victim therapist	> 1% (1)
This decision is not made by the entire team	8.2% (9)

F If contact is approved, the treatment provider and the supervising officer shall closely supervise and monitor the process.

Table 92: Multiple Responses from Telephone Surveys about Additional Requirements Placed on Offenders Who Have Contact With Children

Additional Requirements	Supervising Officer Telephone Responses n=110	Treatment Provider Telephone Responses n=64
Offender has to take tests (Abel, plethysmograph, polygraph); take the polygraph after visits/prior to moving home	32.7% (36)	50% (32)
Discuss contact at treatment and probation; offender must give a full disclosure.	11.8% (13)	3.1% 2
Chaperone has to be approve; the chaperone and the	21.8% (24)	37.5% (24)

child must report back and give feedback.		
Use a safety plan for every visit, relapse prevention, strict terms and conditions are used and the offender must sign a treatment contract.	13.6% (15)	0
Increase home visits, have more frequent contact, more follow up calls.	5.5% (6)	0
Offenders fill out logs and log all incidental contact	9.1% (10)	10.9% (7)
There are no additional provisions	8.2% (9)	0
Weekly individual therapy, discussed in treatment sessions	0	6.1% (4)
Require offender and spouse to attend couples group, spouse/children are in treatment	0	9.4% (6)
Weekly form	0	4.6% (3)
Safety plan; offender is never alone with child	0	3.1% (2)

Table 93: Supervising Officers Telephone Responses about Where Documentation can be Found Allowing Offenders to have Contact with Children

Where is Documentation Located?	**Frequency of Supervising Officer Telephone Responses n=70***
Documented in case plans, chrons, narratives, probation notes	35.7% (25)
Treatment provider has documentation; monthly progress reports; treatment plans, treatment notes	27.1% (19)
Said it is documented with a specific form for 5.7 criteria or memos stating the offender has met criteria	12.9% (9)
With safety plans, visitation contracts, chaperone status form	11.5% (8)
Documented by polygraph results, non deceptive results	8.6% (6)
said the court order is in the file Don't know; a signed "duty to warn" team signed off on it	4.2% (3)

*Seventy supervising officers with offenders who have contact with children.

6.000
STANDARDS FOR POLYGRAPHY

SUMMARY OF FINDINGS:

Reviews of 204 polygraph examination reports found that the Standards *assessed below were followed for nearly every exam.* Further, most polygraph examiners contact the supervising officer and the therapist when important information is obtained from offenders curing the course of the exam, providing immediate feedback on potentially risky situations.

Seventeen polygraph examiners have been approved to conduct post-conviction sex offender examinations and two-thirds have worked with this population for five or more ears. Two-thirds of the examiners said the team approach provides a balanced perspective and 40% said it interferes with offenders' propensity to be manipulative (data not presented). Most (77%) of examiners reported that the offenders were always or sometimes prepared for the exam; three examiners said this was not the case.

6.100 ♦ Standards of Practice for Sex Offender Clinical Polygraph Examiners

Table 94: Polygraph Examiners Telephone Responses about Conducting Post-Conviction Exams Before the *Standards and Guidelines* were Published

	Polygraph Examiner Telephone Responses **n=17**
Yes	29.4% (5)
No	70.6% (12)

Table 95: Telephone Responses from Polygraph Examiners About the Length of Time That They Have Worked with Sex Offenders

	Polygraph Examiner Telephone Responses **n=17**
Less than 5 years	35.3% (6)
Between 5 and 10 years	47.1% (8)
10 years or longer	17.6% (3)

Table 96: Telephone Responses from Polygraph Examiners about the Offender's Readiness for the Polygraph Exam

	Polygraph Examiner Telephone Responses n=16*
Yes	64.7% (11)
No	17.6% (3)
Sometimes	11.8% (2)

*Data missing from one case.

Table 97: Open-ended Question to Polygraph Examiners: What Are the Advantages of a Team Approach?

Most Common Responses from Polygraph Examiner Telephone Surveys About the Advantage of having a Team Approach
1. Different perspectives, share views, balances decision making **2. Interferes with offender manipulation** **3. Learn more about the offender** **4. Improves community safety**

Table 98: Open-ended Question to Polygraph Examiners: What Are the Disadvantages to a Team Approach?

Most Common Responses from Polygraph Examiner Telephone Surveys about the Disadvantages of having a Team Approach
1. Time management, time constraints **2. Communication challenges** **3. Polygraph examiner not considered equal member of the team** **4. Have their favorite polygraph examiners and will only work with them**

6.160 Examiners shall use the following specific procedures during the administration of each examination.

G All test questions must be formulated to allow only Yes or No answers;

Table 99: Evidence in Polygraph Reports that All Test Questions Allow for Yes or No Answers

	Polygraph Reports n=52*
No	98.1% (51)
Yes	1.9% (1)

*There were 54 files that researchers looked at however; two of the files did not contain any polygraph reports.

6.190 Examiners shall issue a written report. The report must include factual, impartial, and objective accounts of the pertinent information developed during the examination, including statements made by the subject. The information in the report must not be biased, or falsified in any way. The examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process. All polygraph examination written reports must include the following:

Date of test or evaluation
Name of person requesting exam
Name of examinee
Location of examinee in the criminal justice system (probation, parole, etc.)
Reason for examination
Date of last clinical examination
Examination questions and answers
Any additional information deemed relevant by the polygraph examiner (e.g. examinees' demeanor)
Reasons for inability to complete exam, information from examinee outside the exam, etc.
Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee.

Table 100: Types of Information that Should Be Included in the Polygraph Examination Written Report

	Documented in the Polygraph Report* **n=52****
Date of test or evaluation	100% (52)
Name of person requesting exam	78.8% (41)
Location of examinee in the criminal justice system	84.6% (44)
Reason for examination	90.4% (47)
Date of last clinical examination	66.7% (28)***
Examination questions and answers	98.1% (51)
Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee	100% (52)

*Researchers coded the most recent polygraph report. The frequencies refer to: yes, the information is documented in the report.
**Researchers examined reports in 54 treatment files. Two of the files did not contain polygraph reports.
*** Ten reports represented first exams. Therefore, the denominator for this figure is 42.

6.111 In order to design an effective polygraph examination and adhere to standardized and recognized procedures the relevant test questions should be limited to no more than four (4) and shall:

Be simple, direct and as short as possible
Not include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms
Not include mental state or motivation terminology
The meaning of each question must be clear and not allow for multiple interpretations
Each question shall contain reference to only one issue under investigation
Never presuppose knowledge on the part of the examinee
Use language easily understood by the examinee and all terms used by the examiner should be fully explained to the examinee
Be easily answered yes or no
Avoid the use of any emotionally laden terminology (such as rape, molest, murder, etcetera) and use language that is behaviorally descriptive

Table 101: Evidence in Polygraph Reports that the Standards for Polygraph Test Questions Are Being Followed

Standards that Polygraph Test Questions Shall Follow **N=52***	
Be simple, direct and as short as possible	
No	1.9% (1)
Yes	96.2% (50)
Somewhat	1.9% (1)
Include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms	
No	82.7% (43)
Yes	15.4% (8)
Somewhat	1.9% (1)
Include mental state or motivation terminology	
No	100% (52)
Yes	0
Somewhat	0
Were clear	
No	0
Yes	96.2% (50)
Somewhat	3.8% (2)
Each question shall contain reference to only one issue under investigation	
No	1.9% (1)
Yes	96.2% (50)

Somewhat	1.9% (1)
Could be easily answered yes or no?	
No	0
Yes	98.1% (51)
Somewhat	1.9% (1)
Included emotionally laden terminology (such as rape, molest, murder, etcetera)	
No	100% (52)
Yes	0
Somewhat	0

*Researchers examined reports in 54 treatment files. Two of the files did not contain polygraph reports.

* * *

SECTION FIVE: BARRIERS TO IMPLEMENTATION

SUMMARY OF BARRIERS:

Professionals mentioned many barriers to the full implementation of the *Standards and Guidelines.* The need for training, the lack of clarification of a few of the *Standards and Guidelines,* and the loss of supervising officers in the current budget reductions and the corresponding excessive caseloads were mentioned as barriers to full implementation. However, many professionals described a variety of ways they sought to overcome impediments to implementation.

Table 102: Telephone Survey Responses about Barriers to Implementing the Standards and Guidelines

	Supervising Officer Telephone Responses n=108*	Treatment Provider Telephone Responses n=63*	Polygraph Examiner Telephone Responses n=17
No	**26.6% (29)**	**30.2% (19)**	**70.6% (12)**
Yes	72.5% (79)	69.8% (44)	29.4% (5)

*Not everyone responded.

Table 103: Telephone Survey Responses about the Types of Barriers Encountered

Ten Most Common Responses about the Types of Barriers Encountered	Number of Responses
1. Difficulties with the judicial process	67
2. Shortage of supervising officers and excessive caseloads	22
3. Standards are not specific enough or there is to much room for interpretation	18
4. Rural locations and travel issues	15
5. Standards are too rigid, leaving no room for exceptions	14
6. Amount of paperwork and layers of bureaucracy	11
7. Differing theoretical approaches	10
8. Financial burdens placed on offenders	10
9. Implementation of 5.7 is rigid and difficult for families and children	9
10. Lack of confidence in the system and compliance is not universal	8

Table 104: Telephone Survey Responses: about if they have Found Ways to Overcome Barriers

	Number of Telephone Responses
No	42.3% (58)
Yes	57.7% (79)

Table 105: Telephone Surveys Responses about Ways of Overcoming Barriers

Ways of Overcoming Barriers
CREATIVITY
• Use of creative scheduling (i.e. schedule the polygraph around the offender's payday) • Utilize the local police department for home visits
COMMUNICATION
• Discuss and work through issues • Disseminate information • Voice one's opinion at monthly SOMB meetings
EDUCATION
• Educate judges and district attorney's • Conduct team trainings (i.e. RAM training for parole officers) • Explain offenders behaviors and patterns to family members • Keep reviewing the *Standards and Guidelines* • Educate others on the appropriateness of the polygraph
TRAVEL
• Make offenders travel vs. team members
INTEGRITY
• Keep public safety in the forefront • Follow professional ethics • Follow the *Standards* as required by law
OTHER
• Document Everything • Identify funding sources • Prioritize, try to follow the Standards as much as possible • Be patient, as in time teams do see the value of the process

Table 106: Telephone Surveys Responses to Impediments to Overcoming Barriers

Reasons	Number of Responses n=25*
▪ **Inability to educate or influence judges or DA's**	**13**
▪ **Lack of flexibility**	**7**
▪ **Lack of funds and resources**	**4**
▪ **Lack of consistent application** ▪ **Lack of a team approach** ▪ **Lack of experience**	**1**

*Not everyone responded.

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SECTION SIX: RECOMMENDATIONS TO ENHANCE THE IMPLEMENTATION OF THE COLORADO *STANDARDS AND GUIDELINES*

Based on the data collected, analyzed and summarized in this report, the Office of Research and Statistics makes the following recommendations to enhance the implementation of the Sex Offender Management Board's (SOMB) adult *Standards and Guidelines*.

1. **Continue the work of modifying, clarifying, revising, and implementing the Standards and Guidelines.** According to interviews with 110 supervising officers and 64 treatment providers, the majority of these professionals said they found the *Standards and Guidelines* useful in their work. Specifically, 98.1% of the supervising officers and 92.2% of treatment providers reported that the *Standards and Guidelines* had a positive impact on their work with sex offenders.

2. **Continue the excellent efforts to include stakeholder participation in monthly board meetings and committee activities.** Collaboration and inclusiveness has been a value expressed by the SOMB since its inception, and many professionals have participated in the Board's work.

   Over three-fourths of the polygraph examiners have attended board meetings (two-thirds have served on committees), one-third of supervising officers have participated in the development of the *Standards and Guidelines,* and over half of the treatment providers interviewed for this study reported attending at least one SOMB meeting.

   The SOMB's use of teleconference technology to increase participation in training events also reflects its commitment to reaching stakeholders outside the Denver-Metro area. The further development and use of the internet list-serve will also enhance communication and participation.

3. **Continue efforts to provide training opportunities for the judges and prosecutors on the *Standards and Guidelines.*** During interviews with 191 therapists, supervising officers and polygraph examiners, two-thirds (67.0%) reported that there are barriers to the implementation of the *Standards and Guidelines*. Mentioned by half of those with implementation concerns--by far the most frequently cited impediment--were difficulties with the judicial process.

   Based on the interview data, training may be useful on the following topics: (1) the role and membership of the SOMB, (2) the process and data used to develop the *Standards and Guidelines,* and (3) the use of information generated from this approach to risk management. Also, training events present important opportunities for dialogue.

4. **Clarify the role of the polygraph examiner as an integral member of the core containment team.** Sixty percent of treatment providers and supervising officers consider the polygraph examiner a member of the containment team. Further, half of the polygraph examiners reported having an adequate amount of contact with treatment providers and 58% said they have adequate contact with supervising officers. Finally, only two-thirds of examiners think that offenders are adequately prepared for the polygraph examination.

   These findings reflect the need to more fully integrate the polygraph examiner into the treatment and supervision team. Examiners need specific information about treatment progress and individual risk factors in order to construct meaningful, individualized test questions. Integrating the examiner into the treatment team is intended to maximize the value of the polygraph exam in the containment approach.

5. **Require documentation of individualized relapse prevention plans in the case files of these professionals.** Relapse prevention concepts remain an important component of managing offenders' abusive behavior. Relapse prevention plans were found in 6 (11.1%) of the 54 treatment provider files, and fewer were found in probation and parole files. However, safety plans developed for specific events such as holidays and family reunions were frequently available in the files. Relapse plans are likely to be "works in progress" and so may remain with the offender as part of homework material. However, the relapse plan should be photocopied regularly and placed in the treatment and supervision files. It serves as critical documentation of pre-assaultive risk factors and includes the offender's prevention tools. Also, this information should be available when necessary to extended members of the case management team, including the victim therapist and family members.

6. **The mental health evaluations and treatment plans should be made available to members of the containment team.** Sex offense specific mental health evaluations were found in the probation officers' files most of the time; however, they were found in 4 of the 15 parole files reviewed. Further, this evaluation was missing in 9 (16.7%) of 54 treatment files reviewed. Treatment plans were missing in 12 (22.2%) of the treatment providers' files.

   The mental health evaluation and the treatment plan provide a significant amount of information about the offender. This information can be incorporated into the supervision plan and the polygraph exam. Individualized goals and clearly defined expectations provide objective methods to assess progress in treatment, and are required by the *Standards and Guidelines.*

7. **Support efforts on the part of the Judicial Branch to restore supervision staff in probation.** The Division of Probation Services lost 42 probation officers last year along with 20 clerical staff, significantly increasing the supervision and clerical workload of officers. When sex offenders are on intensive supervision, the officers' caseloads do not usually exceed 25, allowing for sufficient monitoring of these cases. When sex offenders are not on ISP, they are supervised on regular probation where the average caseload size is 235 offenders. The increased size of these caseloads has resulted in the need to decrease case management standards, meaning that offender contact requirements with the supervising officer are reduced.

   State agency operating budgets have been reduced by approximately 30% in the past two years. At the same time, the number of offenders under supervision continues to increase. Restoring these positions so that caseload sizes can become manageable is critically important to the ongoing successful implementation of the *Standards and Guidelines.*

8. **Continue the extensive effort that is underway to clarify *Standard 5.7* regarding contact with children.** The implementation of *Standard 5.7* was a frequently mentioned problem during the telephone interviews. Two-thirds of supervising officers reported that some offenders on their caseloads have contact with children; many therapists reported that offenders allowed contact have met the SOMB criteria for contact. Finally, in a review of 15 polygraph examinations that questioned the offender's contact with children, over half of the offenders were found to be deceptive on the examination. The SOMB Committee working on developing a risk assessment protocol will provide needed direction and structure to decision making regarding child contact. Any effort the Committee undertakes to require documentation files of the contact decision in the supervising officer will further future research efforts.

9. **Support the development of an ongoing quality control mechanism to monitor and improve the implementation of the *Standards and Guidelines* and to ensure the availability of data necessary for the outcome evaluation.** Studies to determine the outcome of sex offender cases and the impact of the system developed through the implementation of the *Standards and Guidelines* requires complete case management documentation in the files of professionals who work with these offenders. To fulfill the statutory mandate to research the effectiveness of the "treatment procedures, and programs developed" (C.R.S. 16.7-1.103(4)(d)(I)), researchers must be able to locate and record information about offender progress in treatment, violations, sanctions (formal and informal), and the communication efforts of the supervision team, including gaps in communication, so that the impact on offender outcome and the effectiveness of the supervision team can be studied.

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SECTION SEVEN: TRACKING SEX OFFENDERS

Pursuant to C.R.S. 16-11.7-103(4)(d)(I), the SOMB is to track offenders who have been subjected to the evaluation, identification and treatment of the *Standards and Guidelines*.

Methods of Tracking

Tracking convicted sex offenders who are subjected to the *Standards and Guidelines* occurs in multiple ways. First, offenders who register with local law enforcement are identified in a statewide list maintained by the Colorado Bureau of Investigation (CBI). The location of registered offenders as of January 31, 2003 is presented in geographic maps in Appendix G.

Secondly, certain offenders are placed on the CBI website for public notification: (1) those who have been designated as a Sexually Violent Predator (SVP) by the court (2) sex offenders who have a prior conviction for a sex crime, and (3) those who have failed to register with local authorities. As of October 13, 2003, 2 offenders may be found on the CBI web site for qualifying as a sexually violent predator (most SVPs are serving prison sentences), 261 offenders were posted on the web site for having multiple offenses, and 311 are posted for failing to register with local law enforcement. More than 570 offenders are available for viewing on the website.

Thirdly, working in cooperation with technical task force members of the Colorado Integrated Criminal Justice Information System (CICJIS) (representatives include Judicial, CBI, Department of Corrections, Department of Human Services (DHS), and the Colorado District Attorneys Council (CDAC), DCJ's Office of Research and Statistics developed a research database that has been used to track sex offenders released from prison.

Using CICJIS for research purposes requires matching specific offenders to their past arrest and court filing records. Collaboration with researchers at Judicial's Division of Probation Services and analysts at the Department of Corrections is an essential component of the CICJIS research database. The work required to conduct these studies using CICJIS data is complicated and labor intense.

Additional tracking of offenders occurs through special studies mandated by the General Assembly.

- *Annual Lifetime Reports to the General Assembly (November 1)*
- *C.R.S. 16-11.7-103(4)(J) - Living Arrangements Study for the General Assembly (due March 15, 2004)*

Monitoring Offender Recidivism

Since 1996 all offenders convicted of sex crimes and offenders whose original crime was a sexual assault regardless of the final conviction crime designation have been subject to the *Standards and Guidelines*. It is not possible to track the individual behavior of thousands of offenders on probation, in community corrections facilities, in prison and on parole due to the resources required to undertake such an endeavor. However, special recidivism studies of this population can provide insight into the implementation of the *Standards and Guidelines.* Four such studies are described below and information from these studies provided the analysis presented in Appendix H.

- *Actuarial Risk Scale Development Study (1997-2000.)* Pursuant to C.R.S 18-3-414.5, the Office of Research and Statistics in DCJ worked with representatives of the SOMB to develop a risk assessment instrument for use with convicted sex offenders. The study was designed to predict sex offenders' noncompliance with treatment and supervision. The sample consisted of adult male sex offenders who were placed on probation supervision, in community corrections (court diversion or prison transition), on parole, and participated in prison treatment between December 1, 1996 and November 30, 1997. Community-based offenders were selected from the 1st, 2nd, 4th, and 18th judicial districts and ComCor, Inc. in Colorado Springs. The total sample size was 494 and recidivism was defined as revocation, revocation pending, negative treatment termination, escape and new arrest. This study can be found at http://dcj.state.co.us/ors/docs.htm

- *Community Corrections in Colorado (1998-2001*). The Office of Research and Statistics responded to a request from the governor's office to study services delivered to offenders placed in the state community corrections system. Over 3,000 (2574 men and 480 women) offenders who terminated from community corrections in FY1998 were tracked for rearrest and new court filing over a 24 month; this sample included 30 convicted sex offenders. Revocation, rearrest and new filing with the district court were analyzed as recidivism measures. This study can be found at http://dcj.state.co.us/ors/docs.htm.

- *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders (2003).* The Office of Research and Statistics received grant funding from the U.S. Bureau of Justice Assistance to evaluate the Colorado Department of Corrections' Therapeutic Community (TC) for Sex Offenders. All sex offenders released from the DOC over a 7-year period during which the *Standards and Guidelines* were under development or being implemented statewide and in prison. Recidivism was measured as any arrest, new district court filing, and return to prison. This study can be found at http://dcj.state.co.us/ors/docs.htm.

- *Annual Report to the General Assembly on Recidivism by Probationers.* The Office of Probation Services reports annual recidivism rates of offenders on probation and participating in special programming. For this report, the Office of Probation Services undertook a special analysis of sex offenders, presented in the table below. This study can be found on the Division of Probation Services website at http://www.courts.state.co.us/dps/dpsindex.htm.

Information from these studies has been summarized in Appendix H. The data presented in the table suggest the following findings:

1. Revocation rates for convicted sex offenders in Colorado who were under community supervision range from approximately 40% to 50%. This revocation rate is considerably higher than the overall revocation rate for other offenders.[10] This higher revocation rate is likely due to the behavioral expectations of sex offenders as outlined in the *Standards and Guidelines* and monitored by specially trained treatment providers, polygraph examiners and supervising officers.

2. An exception to the high revocation rate among the sex offender samples is the group that participated in intense prison treatment combined with parole supervision. The combination of intense prison treatment with supervision and treatment in the community under the *Standards and Guidelines* resulted in considerably lower failure rates.

3. Intense treatment in prison combined with treatment on parole produced the best outcomes. Those who successfully completed parole supervision were significantly less likely to be rearrested in the years following release into the community. Among prisoners, the combination of intense prison treatment and supervision appears to increased public safety.

[10] Thirty-five percent of offenders in community corrections (Table 1 in 2001 Report by ORS) and 33% of those on adult probation (Table 43 in FY2003 Report by the Division of Probation Services) incurred a revocation during supervision. Parolees sustained a 37% technical violation rate (Table 55, 2002 Annual DOC Statistical Report).

Table 107: Summary of Multiple Studies That Tracked Sex Offenders

	Revocation during supervision period	New arrest within 12 months following program completion	New violent arrest within 12 months following program completion	New criminal filing
Probation*	31-41%	Not available	Not available	3%
Community corrections*	50%	Not available	Not available	
Prison discharge, no prison treatment	Not applicable	34%	14%	17%
Prison discharge, and prison treatment**	Not applicable	16%	7%	7%
Parole,*no prison treatment**	48-53%	23%	8%	1%
Parole* and prison treatment****	16%	6%	1%	6%

* Includes treatment in the community.

**Prison treatment here is participation in the intense therapeutic community for sex offenders, a very intense program.

***Parole includes supervision and sex offender treatment in the community.

* * *

APPENDIX A:

DETAILED LIST OF DESCRIPTIONS OF THE *STANDARDS AND GUIDELINES*

SOMB STANDARDS AND GUIDELINES

1.000 Guidelines for Pre-Sentence Investigations

1.010 Each sex offender should be the subject of a pre-sentence investigation, including a mental health sex offense-specific evaluation, prior to sentencing, even when by statute it is otherwise acceptable to waive the pre-sentence investigation.

1.040 A pre-sentence investigation (PSI) report should address the following:

Criminal history
Education/employment
Financial status
Assaultiveness
Residence
Leisure/recreation
Companions
Alcohol/drug problems
Victim impact
Emotional/personal problems
Attitude/orientation
Family marital and relationship issues
Offense patterns and victim grooming behaviors
Mental health sex offense-specific evaluation report
The potential impact of each sentencing option on the victim(s)

2.000 Standards for Mental Health Sex Offense-Specific Evaluations

2.010 In accordance with Section 16-11-102(1)(b) C.R.S., each sex offender shall receive a mental health sex offense-specific evaluation at the time of the pre-sentence investigation.

2.060 Because of the uncertainty of risk prediction for sex offenders the Board recommends the following approaches to evaluation

Use of instruments that have specific relevance to evaluating sex offenders
Use of instruments with demonstrated reliability and validity
Integration of collateral information
Use of multiple assessment instruments and techniques
Use of structured interviews
Use of interviewers who have been trained to collect data in a non-pejorative manner

2.070 Unless otherwise indicated below, the following evaluation modalities are all required in performing a mental health sex offense-specific evaluation:

Examination of criminal justice information, including the details of the current offense and documents that describe victim trauma, when available
Examination of collateral information, including information from other sources on the offender's sexual behavior
Structured clinical and sexual history and interview
Offense-specific psychological testing
Standardized psychological testing if clinically indicated
Medical examination/referral for assessment of pharmacological needs if clinically indicated
Testing of deviant arousal or interest through the use of the penile plethysmograph or the Able Screen

2.090 A mental health sex offense-specific evaluation of a sex offender shall consider the following:

Sexual evaluation, including sexual developmental history and evaluation for sexual arousal/interest, deviance and paraphilias
Character pathology
Level of deception and/or denial
Mental and/or organic disorders
Drug/alcohol use
Stability of functioning
Self-esteem and ego-strength
Medical/neurological/pharmacological needs
Level of violence and coercion
Motivation and amenability for treatment
Escalation of high-risk behaviors
Risk of re-offense
Treatment and supervision needs
Impact on the victim, when possible

2.110 The evaluator shall recommend:

The level and intensity of offense-specific treatment needs
Referral fro medical/pharmacological treatment if indicated
Treatment of co-existing condition
The level and intensity of behavioral monitoring needed
The types of external controls which should be considered specifically for that offender (e.g. controls of work environment, leisure time, or transportation; life stresses, or other issues that might increase risk and require increased supervision)
Methods to lesson victim impact
Appropriateness and extent of community placement.

Upon request the evaluator (if different from the treatment provider) shall also provide information to the case management team or prison treatment provider at the beginning of an offender's term of supervision or incarceration.

3.000 Standards of Practice for Treatment Providers

3.100 Sex Offense-Specific Treatment

3.110 Sex Offense specific treatment must be provided by a treatment provider registered at the full operating level or the associate level under these standards.

3.130 A provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender.

The treatment plan shall:

Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender
Be individualized to meet the unique needs of the offender
Identify the issues to be addressed, including multi-generational issues if indicated, planned intervention strategies, and the goals of treatment
Define expectations of the offender, his/her family (when possible), and support systems
Address the issue of ongoing victim input

3.140 A provider shall employ treatment methods that are supported by current professional research and practice:

A. Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of psychological treatment used must conform to the standards fro content of treatment and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and shall be avoided except when geographical-specifically rural—or disability limitations dictate its use.

3.150 Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Colorado state law on health care records. Client files shall:

A. Document the goals of treatment, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations and consequences given should be recorded.

B. Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.

3.200 Confidentiality

3.210 A treatment provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality should extend to the victim's therapist. The waiver of confidentiality shall extend to the supervising officer and all members of the team and, if applicable, to the Department of Human Services and other individuals or agencies responsible for the supervision of the offender.

3.220 A provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.

3.300 Treatment Provider-Client Contract

3.310 A provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of treatment. The contract shall define the specific responsibilities of both the provider and the client.

A. The contract shall explain the responsibility of a provider to:

1. Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
2. Describe the waivers of confidentiality which will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
3. Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;
4. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined, and;
5. Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304 C.R.S.

B. The contract shall explain any responsibilities of a client (as applicable) to:

1. Pay for the cost of assessment and treatment for him or herself, and his or her family, if applicable;
2. pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;
3. Inform the client's family and support system of details of past offenses which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;
4. Actively involve relevant family and support system, as indicated in the relapse prevention plan.
5. Notify the treatment provider of any changes or events in the lives of the client and members of the client's family or support system;
6. Participate in polygraph testing as required in the Standards and Guideline and, if indicated, plethysmographic testing and adjuncts to treatment;
7. Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;
8. Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client.

C. The contract shall also, (as applicable):

1. Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;
2. Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;
3. Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high-risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
4. Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff, and;
5. Describe limitations or prohibitions on employment and recreation.

3.600 Community Placement and the Treatment of Sex Offenders in Denial

3.620 Level of denial and defensiveness shall be assessed during the mental health sex offense-specific evaluation.

3.630 When a sex offender in strong or sever denial must be in the community (e.g. on mandatory parole), offense-specific treatment shall begin with an initial module that specifically addresses denial and defensiveness. Such offense-specific treatment for denial shall not exceed six months and is regarded as preparatory for the remaining course of offense-specific treatment.

3.650 Offenders who are still in strong or sever denial and/or are strongly resistant after this six-month phase of treatment shall be terminated from treatment and revocation proceeding should be initiated if possible. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if revocation is not an option. In no case should a sex offender in continuing denial of the facts of the offense remain indefinitely in offense-specific treatment.

3.700 Treatment Providers' Use of the Polygraph and Plethysmograph and Abel Screen

3.720 It is recommended that a provider employ plethysmography as a means of gaining information regarding the sexual arousal patterns of sex offenders or the Abel screen as a means of gaining information regarding the sexual interest patterns of sex offenders.

3.730 In cooperation with the supervising officer, the provider shall employ treatment methods that incorporate the results of polygraph examinations, including specific issue polygraphs, disclosure polygraphs, and maintenance polygraphs. Exceptions to the requirement for use of the polygraph may be made only by the case management team or by a prison treatment provider.

3.740 The case management team shall determine the frequency of polygraph examinations, and the results shall be reviewed by the team. The results of such polygraphs shall be used to identify treatment issues and for behavioral monitoring.

5.000 Standards and Guidelines for Management of Sex Offenders on Probation Parole and Community Correction

5.100 Establishment of an Interagency Community Supervision Team

5.120 Each team, at a minimum, should consist of:

The supervising officer
The offender's treatment provider and
The polygraph examiner

Each team is formed around a particular offender and is flexible enough to include any individuals necessary to ensure the best approach to managing and treating the offender. Team membership may therefore change over time.

The team may include individuals who need to be involved at a particular stage of management or treatment (e.g., the victim's therapist or victim advocate). When the sexual offense is incest, the child protection worker is also a team member if the case is still open.

5.160 Team members should communicate frequently enough to manage and treat sexual offenders effectively, with community safety as the highest priority.

5.200 Responsibilities of the Supervising Officer for Team Management

5.210 The supervising officer shall refer sex offenders for evaluation and treatment only to treatment providers who meet the standards. (Section 16-11.7-106 C.R.S.)

5.220 The supervising officer should ensure that sex offenders sign releases for at least the following types of information:

Releases of information to treatment providers, including information from any treatment program in which the offender participated in the Department of Corrections;
Releases of information to case management team members, including collateral information sources, as indicated, such as the child protection agency, the treatment provider, the polygraph examiner, the victim's therapist, and any other professionals involved in treatment and/or supervision of the offender;
Releases of information to the victim's therapist, the guardian ad litem, custodial parent, guardian, caseworker, or other involved professional, as indicated. Such information may be used in the victim's treatment and/or in making decisions regarding reunification of the family or the offender's contact with the victim.

5.230 The supervising officer, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions. The

information provided by the team should include date and results of last polygraph examination.

5.240 The supervising officer should require sex offenders to provide a copy of the written plan developed in treatment for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising officer should utilize the relapse prevention plan in monitoring offenders' behavior.

5.250 The supervising officer should require sex offenders to obtain the officer's written permission to change treatment providers.

5.260 The supervising officer should ensure maximum behavioral monitoring and supervision for offenders in denial. The officer should use supervision tools that place limitations on offenders' use of free time and mobility and emphasize community safety and containment of offenders.

5.270 The supervising officer should require treatment providers to keep monthly written updates on sex offenders' status and progress in treatment.

5.280 The supervising officer should discuss with the treatment provider, the victim's therapist, custodial parent or foster parent, and guardian ad litem specific plans for any and all contacts of an offender with a child victim and plans for family reunification.

5.290 The supervising officer should develop a supervision plan and contact standards based on a risk assessment of each sex offender, the sex offender's offending cycle, physiological monitoring results, and the offender's progress in treatment

5.216 The supervising officer should notify sex offenders that they must register with local law enforcement, in compliance with Section 18-3-412.5 C.R.S.

5.222 Supervising officers assessing or supervising sex offenders should successfully complete training programs specific to sex offenders. Such training shall include information on:

Prevalence of sexual assault
Offender characteristics
Assessment/evaluation of sex offenders
Current research
Community management of sex offenders
Interviewing skills
Victim issues
Sex offender treatment
Choosing evaluators and treatment providers
Relapse prevention
Physiological procedures

Determining progress
Offender denial
Special populations of sex offenders
Cultural and ethnic awareness

It is also desirable for agency supervisors of officers managing sex offenders to complete such training.

5.223 On an annual basis, supervising officers should obtain continuing education/training specific to sex offenders.

5.300 Responsibilities of the Treatment Provider within the Team

5.310 A treatment provider shall establish a cooperative professional relationship with the supervising officer of each offender and with other relevant supervising agencies. This includes but may not be limited to:

A. A provider shall immediately report to the supervising officer all violations of the provider/client contract, including those related to specific conditions of probation, parole, or community corrections;

B. A provider shall immediately report to the supervising officer evidence or likelihood of an offender's increased risk of re-offending so that behavioral monitoring activities may be increased;

C. A provider shall report to the supervising officer any reduction or duration of contacts or any alteration in treatment modality that constitutes a change in an offender's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual case basis by the provider and the supervising officer

D. On a timely basis, and no less than monthly, a provider shall provide to the supervising officer progress reports documenting offenders' attendance, participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress.

E. If a revocation of probation or parole is filed by the supervising officer, a provider shall furnish, when requested by the supervising officer, written information regarding the offender's treatment progress. The information shall include: changes in the treatment plan, dates of attendance, treatment activities, the offender's relative progress and compliance in treatment, and any other material relevant to the court at the hearing. The treatment provider shall be willing to testify in court if necessary.

F. A provider shall discuss with the supervising officer, the victim's therapist, custodial parent and/or guardian ad litem specific plans for any and all contacts of the offender with the child victim and plans for family reunification.

G. A provider shall make recommendations to the supervising officer about visitation supervisors for an offender's contact with children, if such contact is allowed.

5.400 Responsibilities of the Polygraph Examiner within the Team

5.410 The polygraph examiner shall participate as a member of the post-conviction case management team established for each sex offender

5.420 The polygraph examiner shall submit written reports to each member of the community supervision team for each polygraph exam as required in section 6.190. Reports shall be submitted in a timely manner, no longer than two weeks post testing.

5.430 Attendance at team meetings shall be on an as-needed basis. At the discretion of the supervising officer, the polygraph examiner may be required to attend only those meeting preceding and /or following an offender's polygraph examination, but the examiner is nonetheless an important member of the team.

5.500 Conditions of Community Supervision

5.510 In addition to general conditions imposed on all offenders under community supervision, the supervising agency should impose the following special conditions on sex offenders under community supervision:

A. Sex offenders shall have no contact with their victim(s), including correspondence, telephone contact, or communication through third parties except under circumstances approved in advance and in writing by the supervising officer in consultation with the community supervision team. Sex offenders shall not enter onto the premises, travel past, or loiter near the victim's residence, place of employment, or other places frequented by the victim;

B. Sex offenders shall have no contact, nor reside with children under the age of 18, including their own children, unless approved in advance and in writing by the supervising officer in consultation with the community supervision team. The sex offender must report all incidental contact with children to the treatment provider and the supervising officer as required by the team;

C. Sex offenders who have perpetrated against children shall not date or befriend anyone who has children under the age of 18, unless approved in advance and in writing by the supervising officer in consultation with the community supervision team;

D. Sex offenders shall not access or loiter near school yards, parks, arcades, playgrounds, amusement parks, or other places used primarily by children unless approved in advance and in writing by the supervising officer in consultation with the community supervision team;

E. Sex offenders shall not be employed in or participate in any volunteer activity that involves contact with children, except under circumstances approved in advance and in writing by the supervising office in consultation with the community supervision team;

F. Sex offenders shall not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, computer programs or services. Sex offenders shall not patronize any place where such material or entertainment is available. Sex offenders shall not utilize any sex-related telephone numbers. The community supervision team may grant permission for the use of sexually oriented material for treatment purposes;

G. Sex offenders shall not consume or possess alcohol;

H. The residence and living situation of sex offenders must be approved in advance by the supervising officer in consultation with the community supervision team. In determining whether to approve the residence, the supervising officer will consider the level of communication the officer has with others living in the residence, and the extent to which the offender has informed household members or his/her conviction and conditions of probation/parole/community corrections, and the extent to which others living in the residence are supportive of the case management plan;

I. Sex offenders will be required to undergo blood, saliva, and DNA testing as required by statute;

J. Other special conditions that restrict sex offenders from high-risk situations and limit access to potential victims may be imposed by the supervising officer in consultation with the community supervision team;

K. Sex offenders shall sign information releases to allow all professionals involved in assessment, treatment, and behavioral monitoring and

compliance of the sex offender to communicate and share documentation with each other;

L. Sex offenders shall not hitchhike or pick up hitchhikers;

M. Sex offenders shall attend and actively participate in evaluation and treatment approved by the supervising officer and shall not change treatment providers with out prior approval of the supervising officer.

5.600 Behavioral Monitoring of Sex Offenders in the Community

5.610 The monitoring of offenders' compliance with treatment and sentencing requirements shall recognize sex offenders' potential to re-offend, to re-victimize, to cause harm, and the limits of sex offenders' self-reports:

A. Responsibility for the behavioral monitoring activities shall be outlined under explicit agreements established by the supervising officer. Some or all members of the team described in Section 5.000 will share monitoring responsibility. At a minimum, the provider, the supervising officer, and the polygraph examiner shall take an active role in monitoring offenders' behaviors;

For purposes of compliance with this standard, behavioral monitoring activities shall include, but are not limited to the following: (For some activities, monitoring and treatment overlap).

1. The receipt of third-party reports and observations;

2. The use of disclosure and maintenance polygraphs; measures of arousal or interest including sexual and violent arousal or interest;

3. The use and support of targeted limitations on an offenders' behavior, including those condition set forth in Section 5.500;

4. The verification (by means of observation and/or collateral sources of information in addition to the offender's self report) of the offender's:

a) Compliance with sentencing requirements, supervision conditions and treatment directives;

b) Cessation of sexually deviant behavior;

c) Reduction of behaviors most likely to be related to a sexual re-offense;

d) Living, work and social environments, to ensure that these environments provide sufficient protection against offenders' potential to re-offend;

e) Compliance with specific conditions of the relapse prevention plan;

5. The direct involvement of individuals significant in the offenders' life in monitoring offenders' compliance, when approved by the community supervision team.

B. Behavioral monitoring should be increased during times of an offender's increased risk to re-offend, including, but not limited to, such circumstances as the following:

1. The offender is experiencing stress or crisis;

2. The offender is in a high-risk environment;

3. The offender will be having visits with victims or potential victims, as recommended by the provider and approved by the supervising officer, victim treatment provider, custodial parent, and/or guardian ad litem;

4. The offender demonstrates a high or increased level of denial.

5.700 Sex Offenders' Contact with Victims and Potential Victims

5.710 For purposes of compliance with this standard, supervising officers and providers shall:

A. Whenever possible, collaborate with an adult victim's therapist or advocate, or a child victim's therapist, guardian, custodial parent, foster parent, and/or guardian ad litem, in making decisions regarding communication, visits, and reunification;

B. Support the victim's wishes when the victim does not wish to have contact with the offender;

C. Arrange contact in a manner that places child and/or victim safety first. When assessing safety, both psychological and physical well-being shall be considered;

D. Ensure consultation with custodial parents or guardians of a child victim and the child's guardian ad litem and treatment provider prior to authorizing contact and that contact is in accordance with court directives:

E. Before recommending contact with a child victim or any potential victims, assess the offender's readiness and ability to refrain from re-victimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the child's personal space, and to recognize and respect the child's indication of comfort or discomfort. In addition, the following criteria must be met before visitation can be initiated:

1. Sexually deviant impulses are at a manageable level and the offender can utilize cognitive and behavioral interventions to interrupt deviant fantasies;

2. The offender is willing to plan for visits, to develop and utilize a safety plan for all visits and to accept supervision during visits;

3. The offender accepts responsibility for the abuse;

4. Any significant differences between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved:

5. The offender has a cognitive understanding of the impact of the abuse on the victim and the family;

6. The offender is willing to accept limits on visits by family members ant eh victim and puts the victim's needs first;

7. The offender has willingly disclosed all relevant information related to risk to all necessary others;

8. The clarification process is complete;

9. Both the offender and the potential visitation supervisor have completed training addressing sexual offending and how to participate in visitation safely;

10. The offender and the potential supervisor understand the deviant cycle and accept the possibility of re-offense. The offender should also be able to recognize thinking errors;

11. The offender has completed a non-deceptive sexual history disclosure polygraph and at least one non-deceptive maintenance polygraph. Any exception to the requirement for a non-deceptive sexual history disclosure polygraph must be made by a consensus of the community supervision team;

12. The offender understands and is willing to respect the victim's verbal and non-verbal boundaries and need for privacy;

13. The offender accepts that others will decide about visitation, including the victim, the spouse and the community supervision team.

F. If contact is approved, the treatment provider and the supervising officer shall closely supervise and monitor the process:

1. There must be provisions for the monitoring behavior and reporting rule violations to the supervising officer;

2. Victims' and potential victims' emotional and physical safety shall be assessed on a continuing basis and visits shall be terminated immediately if any aspect of safety is jeopardized;

3. Supervision is critical when any sex offender visits with any child; supervision is especially critical for those whose crimes are know to have been against children, and most of all during visitation with any child previously victimized by the offender. Any behavior indicating risk shall result in visits being terminated immediately;

4. Special consideration should be given when selecting visitation supervisors. The visitation supervisor shall have some relationship with the child, be fully aware of the offense history including patterns associated with grooming, coercion, and sexual behaviors and be capable and

willing to report any infractions and risk behaviors to the community supervision team members. If the supervisor is not known to the child, then the child's current care giver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision.

6.000 Standards for Polygraphy

6.100 Standards of Practice for Sex Offender Clinical Polygraph Examiners

6.190 Examiners shall issue a written report. The report must include factual, impartial, and objective accounts of the pertinent information developed during the examination, including statements made by the subject. The information in the report must not be biased, or falsified in any way. The examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process. All examination written reports must include the following:

Date of test or evaluation
Name of person requesting exam]
Name of examinee
Location of examinee in the criminal justice system (probation, parole, etc)
Reason for examination
Date of last clinical examination
Examination questions and answers
Any additional information deemed relevant by the polygraph examiner, eg: examinee's demeanor
Reasons for inability to complete exam, information from examinee outside the exam, etc.
Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee.

6.111 In order to design an effective polygraph examination and adhere to standardized and recognized procedures the relevant test question s should be limited to no more than four and shall:

Be simple, direct and as short as possible
Not include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms
Not include mental state or motivation terminology
The meaning of each question must be clear and not allow for multiple interpretations
Each question shall contain reference to only one issue under investigation
Never presuppose knowledge on the part of the examiner
Use language easily understood by the examinee and all terms used by the examiner should be fully explained to the examinee
Be easily answered yes or no
Avoid the use of any emotionally laden terminology (such as rape, molest, murder, etc.) and use language that is behaviorally descriptive.

APPENDIX B:

INTERVIEW QUESTIONNAIRES

DCJ SUPERVISING OFFICER ID__ __ __

Supervising Officers -Telephone Survey #1

Name of Supervising Officer:

Probation Officer__ **Parole Officer__**

Survey #1 X Yes	**Administer to all supervising officers**
Survey #2 ___ ___ Yes No	**Did you supervise sex offenders in Colorado Communities before the development of the Standards and Guidelines (before 1996)?** **When did you start supervising sex offenders? (enter year __ __)**
The supervising officer may have several offenders in the CASE FILE SAMPLE. You need to get the therapist names for all of these offenders. **FILL IN OFFENDER NAMES IN CASE FILE SAMPLE BEFORE THE INTERVIEW** **IF THE SUPERVISING OFFICER DOES NOT CURRENTLY SUPERVISE THE OFFENDER IN THE CASE FILE, FIND OUT IF ANOTHER OFFICER DOES OR WHAT HAPPENED TO THE OFFENDER**	**Do you still supervise (_____)** 1=yes,0=no **Offender's Name** **If yes, who is their current tx provider _____** **If no, who does or what happened?_____** **_____** **Do you still supervise (_____)** 1=yes,0=no **Offender's Name** **If yes, who is their current tx provider _____** **If no, who does or what happened?_____** **_____** **Do you still supervise (_____)** 1=yes,0=no **Offender's Name** **If yes, who is their current tx provider_____** **If no, who does or what happened? _____** **_____** **Do you still supervise (_____)** 1=yes,0=no **Offender's Name** **If yes, who is their current tx provider _____** **If no, who does or what happened?_____** **_____**

Use the introduction that describes the surveys to be administered (USE ONLY ONE):

Introductions:

Check appropriate box for this provider	
❑ **Survey #1**	***"I'd like to ask you some questions about your work with sex offenders and the other members of the sex offender treatment and supervision team. The interview should take about 45 minutes."***
❑ **Surveys #1, #2**	***"First I'd like to ask you some questions about your work with sex offenders and other members of the sex offender management team. Then I'd like to ask a few questions in regard to the standards and guidelines and changes you may have perceived since their initial implementation The interview should take about an hour."***

"FIRST I'D LIKE TO ASK YOU SOME GENERAL QUESTIONS"

Q1. How many sex offenders do you currently supervise?_____

Q2. How many NON sex offenders do you currently supervise?_____

Q3. Do you currently supervise other officers?

1 Yes
0 No

"NOW I'D LIKE TO ASK A FEW QUESTIONS ABOUT SUPERVISION OR CASE PLANS FOR SEX OFFENDERS"

Q4. Do you distinguish between case/supervision plans and terms and conditions of supervision?

0 No
1 Yes, and if yes

When developing case/supervision plans for sex offenders what considerations/issues or input do you typically include? ***(if necessary provide examples like criminal history, victim input, etc.)***

(probe: anything else?)

5.290 (What do you include)	**(How do you use this information in the plan)**

Q5. When did you first receive training on providing supervision to sex offenders? (insert year) __ __

Confirm that this was before or after the officer began supervising sex offenders by looking at the cover sheet.

1 Before officer began supervising sex offenders
0 After officer began supervising sex offenders
2 Has not yet received any training
8 Can't remember. (If officer does not remember just ask if it was before or after supervising sex offenders)

Q6. What type of training did you receive? (*code up to 4*)

_____
_____
_____
_____
_____
_____

Q7. Do you receive additional training or continuing education specific to sex offenders? (5.223)

1 Yes
IF YES, how often:_____
IF YES, what type of training: _____
0 No
8 Been here less than a year

Q8. Do you feel like you have an adequate amount of training to supervise sex offenders?

1 Yes
0 No. What would be useful?

(for probation officers) **(for parole officers)**

Q9. Do you attend SOS(Sex Offender Supervision) or RAM(Risk Assessment Management) Meetings?

1 Yes. How often_____
0 No
IF NO, do you attend an alternative to an SOS or RAM meeting?
1 Yes. What? _____
0 No. Would you like to attend something like this?

Q10. Have you ever attended the monthly SOMB meetings?

1 Yes, how many times? _____
0 No

Q11. Have you ever served on any of the SOMB sub-committees?

1 Yes, which?_____ _____ _____
0 No

"THE FOLLOWING QUESTIONS ARE ABOUT HOW YOU EXCHANGE INFORMATION WITH THE OFFENDER'S TREATMENT PROVIDER"

Q12. In general, how often do you talk to the treatment provider about specific cases?

(DO NOT READ RESPONSES, but circle as many as apply--try to get somewhat specific responses. For instance, if the respondent says "all the time," try to narrow that down. If s/he says "sometime a lot and sometimes never," try to find out in which situations the respondent speaks to the therapist frequently, and in which situations they never speak. Then try to code the responses in the following categories: add others if necessary)

1 Between daily and weekly
2 More than monthly but less than weekly (*e.g., 2-3 times a month)*
3 Monthly
4 Every couple of months
5 Never
6 For specific situations *(depends on offender, when offender is "high risk",as needed, for deception)*
7 Varies (probe, e.g., when do you and when do you not talk to therapists:_____
_____
8 Other:_____
9 Other:_____

Q13. Do you receive WRITTEN progress reports from treatment providers for sex offenders on your caseload? DO NOT READ

0 No
4 Get updates through telephone calls. How often?_____
3 Sometimes, depends on provider. How often?_____
2 Sometimes. How often?_____
1 Yes. How often?_____

IF THEY RECEIVE PROGRESS REPORTS ASK Q14 AND COMPLETE THE TABLE BELOW:

Q14. What types of information do you typically receive about the offender in progress reports? ***DO NOT READ (Probe "anything else"*****)**

If the respondent indicates that s/he receives a "generic check list" or "gets updates," find out what is typically included:

(***enter a 1 if mentioned)***

	Treatment **ATTENDANCE**		General: **How they've been doing**
	Treatment **PARTICIPATION**		**SEX HISTORY** Information
	Treatment **PROGRESS**		Other (describe)
	Treatment **PLAN UPDATES**		
	Treatment **COMPLIANCE**		
	Treatment **LEVEL CHANGES**		
	Increased/Decreased **RISK**		
	New/Updated **EVALUATIONS** (pyschosexual and risk)		
	VIOLATIONS		
	Following **RULES**/or not		
	POLYGRAPH results		
	POLY OR PLETHYS scheduled		
	Other **TEST RESULTS**		

See S & G 5.310 for circumstances where provider should contact the supervising officer

Q15. Other than progress reports under what circumstances does a treatment provider contact you about an offender?

DO NOT READ (probe--anything else?)

Place a "1" here if mentioned; OTHERWISE, LEAVE BLANK	
	Offender **violates provider/client contract, including specific conditions of probation, parole or community corrections**
	Evidence or likelihood of an **offender's increased risk** of re-offending
	When there is a **reduction in frequency or duration of contacts**
	When there is a **change in treatment modality**/treatment plan
	When offender is **not complying** with treatment
	To discuss/inform about **employment issues**
	To discuss/inform about **housing issues**
	To discuss **payment for services**
	To discuss/inform about **offender's progress in treatment**
	Offender could be **danger to self or others**
	To discuss/inform about **new disclosures of victims**
	To discuss inform/ about **new disclosures of behaviors**
	To **provide information REQUESTED BY the supervising officer**
	When arranging **contacts between the offender and a child victim**
	When there are plans for **family reunification**
	To discuss **visitation supervisors** for an offender's contact with children
	To discuss the results of **polygraphs.**
	Other, describe:
	Other, describe:
	Other, describe:
	Other, describe:
	Other, describe

Q16. For what reasons DO YOU usually contact a treatment provider?

(See section 5.200 for Supervising officer responsibilities)

DO NOT READ (prompt--anything else?)

	To **refer** an offender for evaluation/treatment
	To **discuss/inform about** results of **polygraphs**
	To discuss/inform about behavioral **monitoring**
	To **arrange team conferences/staffings**
	To **obtain** copies of the **treatment plan/monthly reports or other information**
	To **obtain a risk assessment** or information about offender risk
	To **get updates** about the offender
	To **discuss plans for contacts with children**
	To discuss **family reunification**
	To report about **contact with victim**
	To report contacts with **potential victims**
	To discuss **specific incidents**
	To discuss **disclosures**
	To discuss **offender leaving the state or traveling**
	To talk before the **polygraph**
	To **request than an offender be terminated from treatment** (if this is noted ask why that would occur)
	If the **offender were to be violated or revoked**
	General: **Get information/check in**
	Other, describe:
	Other, describe:
	Other, describe:
	Other, describe:
	Other, describe:
	Other, describe:

Q17. Do you think that you have an adequate amount of contact with the treatment provider?

1 Yes
2 Somewhat
0 No

<u>IF NO OR SOME,</u> what would be better?

"THE NEXT SECTION IS ABOUT HOW POLYGRAPH EXAMINERS FIT INTO YOUR WORK SUPERVISING SEX OFFENDERS"

Q18. Do you receive copies of the polygraph report from the polygraph examiner?

1 Yes, always or almost always
2 Yes, more than half the time but not always
3 Yes, less than half the time
0 Never or seldom

Q19. How do you use the results of the polygraph?

_____
_____

Q20. Do you have input into the question content for the polygraph exam?

1 Always or most always (Is this useful, why?)
_____
2 Sometimes (Is this useful, why?) _____
0 Never or seldom (Is there a reason?)_____

Q21. Do you talk to polygraph examiners about offenders on your caseload?

1 Yes (probe: under what circumstances/when does this happen, etc?)
_____
2 Sometimes (probe: under what circumstances/when does this happen, etc?)
_____
0 No (probe about possible reasons:)_____
_____

Q22. Do you think the polygraph is useful or detrimental, or some of both in supervising and monitoring sex offenders?

1 The polygraph is useful

If the respondent thinks the polygraph is useful, find out why? If response is something like "can better manage" try to get more specific information. (DO NOT READ, insert a 1 for all positive responses, leave the remaining blank)

	To determine **compliance**
	To get **sex history/learn more about disclosures/victims**
	To gain **insight about the offender**
	To address **denial**
	To address **specific situations (**e.g., high risk, suspicions)
	To learn more about offender's **risk of re-offending**
	To keep them "honest"/promotes honesty
	Other:

0 Respondent thinks polygraph is detrimental. (*Probe, why?)*

"NOW I'D LIKE TO ASK A FEW QUESTIONS ABOUT CONSEQUENCES AND SANCTIONS USED WITH AN OFFENDER"

Q23. Do you sanction or impose consequences when an offender has deceptive polygraph results?

1 Yes
0 Depends or sometimes *(probe for reasons:)*

IF YES OR DEPENDS/SOMETIMES, what types of sanctions or consequences do you impose for deceptive polygraphs?

0 No

Q24. Do you sanction or impose consequences when an offender has inconclusive polygraph results?

1 Yes
1 Depends or sometimes *(probe for reasons:)*

IF YES OR DEPENDS/SOMETIMES, what types of sanctions or consequences do you impose for inconclusive polygraphs?

0 No

Q25. In what *<u>other</u>* types of situations do you sanction or impose consequences on an offender?

List the situations	***What types of sanctions/consequences are imposed for this situation?***

"NOW I WOULD LIKE TO ASK SOME QUESTIONS ABOUT THE SUPERVISION AND TREATMENT TEAM AND HOW DECISIONS ARE MADE"

Q26. Typically, who is included as part of the supervision and treatment team for the sex offenders you manage? ***DO NOT READ RESPONSES, BUT Probe: Is anyone else TYPICALLY included?***

(insert a 1 for all mentioned)

	Therapist
	Polygraph Examiner
	Victim Advocate/Therapist
	Other:
	Other:
	Other:

Q27. Typically, do ALL the team members meet as a group to discuss specific cases?

1 Yes

Do you meet over the phone or in person?

1 Phone
2 In Person
3 Both

How often do you typically meet as a team on offenders?

_____

_____

Do you think team meetings occur often enough?

1 Yes
0 No

IF NO, what would be more helpful?

2 SOME of the team members meet.

Which team members typically meet?

_____

_____

Why do some team members meet and not others?

_____

_____

Do you meet over the phone or in person?

1 Phone
2 In Person
3 Both

How often do these team members meet to discuss offenders?

_____

_____

Do you think team meetings occur often enough?

1 Yes
0 No. What would be more useful?

0 NO, typically team members do not meet.

Why is that?

_____

_____

IF NO, do you and team members have other ways to share information? What?

_____

_____

Q28. Are there certain DECISIONS about an offender that are always or almost always made by the <u>entire team</u>, that is (*list all the people the respondent has mentioned in Q23)*

1 Yes
2 Sometimes

IF YES OR SOMETIMES, what types of decisions are team decisions?

__Contact with children (*Check if they mention contact with childre*n)

_____

_____

_____

0 No
IF NO

Typically, which decisions are NOT made by the entire team?

Insert 1	**Decision**	**Who makes the decision**
	Contact with children	

IF THE RESPONDENT HAS NOT ALREADY ADDRESSED DECISION MAKING PROCESS REGARDING CONTACT WITH CHILDREN, ASK Q26. OTHERWISE MOVE TO Q27.

Q29. Who makes the decision about contact with children (as an exception to the conditions of supervision)?

(***If respondent indicates that the team makes this decision, and the Polygraph examiner is a member of the team, verify that the PE is included in the decision about contact with children.)***

_____
_____
_____

Q30. If a child victim has an advocate or a therapist, is this person involved in decisions to allow offender contact with the victim?

0 No
1 Yes, how?

_____
_____

2 Most children do not have an advocate or therapist

Q31. Are any of the offenders you currently supervise permitted contact with children?

0 No, PROCEED TO Q29.

1 Yes  *continue with the questions on this page*

How many offenders of the offenders that you currently supervise are permitted contact with children?__ __

Are restrictions associated with this contact?

0 No
1 Yes
IF YES, what are these restrictions?

_____

What types of contact with children are permitted?

_____
_____

How was the decision made or for what reasons were these offenders permitted contact with children?

_____
_____
_____

Are there additional provisions to the treatment/supervision of the offender that address monitoring the offender's contact with children? What are they?

_____
_____
_____

Do offenders who are permitted contact with children meet the SOMB criteria for contact with children?

Note: The researcher should be thoroughly familiar with this section of the Standards and Guidelines.

1 Yes

IF YES, is this typically documented in the file?

0 No *(note any comments the respondent may have, e.g., we discuss over the phone, but no formal documentation)*_____
_____
_____

1 Yes. How?
_____
_____
_____

0 No

Of the offenders currently on your caseload who have contact with children, are any of these children known victims of the offender?

3/7/0212/2/040 No
8 Don't Know
1 Yes

IF YES, do these victims want contact with the offender?

1 Yes
2 Some do, some don't
0 No

"I HAVE A FEW MORE QUESTIONS ABOUT THE TEAM"

Q32. Do the sex offender teams you work with experience conflict?

0 No

1 Yes. What causes conflict?

2 Some do, some don't. What causes conflict?

IF YES OR SOME, have you developed successful ways to resolve conflict?

2 No

3 Yes. What are they? What would be useful to others in the same situation?

Q33. What, if any, are the pluses about a team approach to managing and treating the sex offenders?

Q34. What, if any are the minuses about a team approach to managing and treating sex offenders?

"THE LAST FEW QUESTIONS IN THIS SECTION REFER TO THE SOMB STANDARDS AND GUIDELINES"

Q35. Are there problems or barriers to implementing the SOMB Standards and Guidelines?

0 No
1 Yes. What are they?

Q36. Have you found ways to overcome these problems and barriers?

0 No. What has gotten in the way of trying to overcome these problems?

1 Yes. What were they?

Q37. Which standards, if any, should be reconsidered? Why?

Q38. Do you think there are important issues that are not covered or are not adequately covered by the standards?

0 No
1 Yes. Which issues?

Q39. Do you think that the Standards and Guidelines are useful?

0 No. Why not?

1 Yes. Why?

Q40. Do you feel as if you have had input into the process of developing the standards?

0 No. Is there a particular reason why you feel you have not had input?

1 Yes. How have you had input?

Q41. Do you have suggestions for how the SOMB could be more effective in implementing the standards?

0 No

1 Yes. What are they?

DCJ TREATMENT PROVIDER ID __ __ __

Treatment Provider -Telephone Survey #1

Name of Provider:

Survey #1 X Yes	**Administer to all providers**
Survey #2 ___ ___ Yes No **Qsurvey2.**	**Did you treat sex offenders in Colorado Communities before the development of the Standards and Guidelines (before 1996)?** **How long have you been treating sex offenders? (Interviewer, please code in months (__ __ __) Qtime.**

Use the introduction that describes the surveys to be administered (USE ONLY ONE):

Introductions:

Check appropriate box for this provider	
❑ **Survey #1**	***"I'd like to ask you some questions about your work with sex offenders and the other members of the sex offender treatment and supervision team. The interview should take about …"***
❑ **Surveys #1, #2**	***"First I'd like to ask you some questions about your work with sex offenders and other members of the sex offender management team. Then I'd like to ask a few questions in regard to the standards and guidelines and changes you may have perceived since their initial implementation The interview should take about …"***

"FIRST I'D LIKE TO ASK YOU A COUPLE OF GENERAL QUESTIONS"

Q1YRS.Q1MOS. **How long have you been working with sex offenders? (years__ __, months__**

Q2COYRS, Q2COMOS. QHow long have you been working with sex offenders in <u>Colorado</u>?(years__ __, months__ __)

Q3. Have you ever worked as a victim therapist?

1 Yes
0 No

Q4. How many sex offenders do you currently treat? __ __

Q5. Do you currently supervise other providers?

1 Yes
If Yes, how many?__ __(**Q5A)**
0 No

Q6. Typically, how many therapists in the groups you run?__ __

Q7. Do you work with offenders in rural areas, urban areas or both?

1 Rural
2 Urban
3 Both

Q8. What proportion of your current adult clients are first time offenders?__ __ __%
(insert 888 for dk)

Q9. Do you graduate offenders from your programs?

0 No
1 Yes
How do you determine when they are ready to graduate?

(Q9A TO Q9E)

_____
_____
_____

Q10. Do you work with offender family members?

0 No
1 Yes (circle all that apply)
Who are they?
1 Spouses male (Q10A)
2 Spouses female (Q10B)
3 Male Children (Q10C)
4 Female Children (Q10D)
5 Other Adult relatives:(who)_____(Q10E)
6 Other Child relatives: who)_____(Q10F)
7 Other:_____(Q10G)

Q11A-Q11D. What would help your clients remain offense free while they are in the community?

_____
_____
_____

_____

_____

Q12A-Q12D. What is the hardest part of the work you do?

_____

_____

_____

"Now I'd like to ask a few questions about treatment plans for sex offenders"

Q13. Are treatment plans individually developed for each sex offender you treat or do they typically contain standard language that is applied to all sex offenders?

0 Typically do not do treatment plans
1 Individualized
2 Standard Language
3 Both

When developing treatment plans for sex offenders do you address:

	1=Yes 0=No	**If YES, how is it addressed?**
Q14.1A Contact with Children		**Q14.2A**
Q14.1B Victim Input		**Q14.2B**
Q14.1C Impact of the offense on the victim		**Q14.2C**
Q14.1D Relapse prevention		**Q14.2D**
Q14.1E		**Q14.2E**
Q14.1F		**Q14.2F**
Q14.1G		**Q14.2G**

Q15. Do you update the treatment plan in writing?

0 No
1 Yes

If yes**,** how often:_____**(Q15A)**

Q15B. 1-Q15B.6 IF YES, do you provide other members of the treatment supervision team with treatment plan updates? ***(Do not read but circle all that apply)***

1 Yes, supervising officer only
2 Yes, the PE only
3 Yes, supervising officer and PE
4 Other: _____
5 Other: _____
0 No

Q15C. If 1, 2 or 3, How do you provide these updates?

1 Usually by phone
2 Usually in writing (includes emails)
3 Sometimes the phone, sometimes in writing
4 Other: _____

"Now, I have some questions about how information is exchanged among members of the supervision and treatment team"

Q16. Generally, do you work only with probation officers, only with parole officers or is there a mix?

1 Work only probation officers
2 Work only with parole officers
3 Work with both
8 Don't know

Note: The answer to this question determines which of the following questions you ask.

***Q17. IF TREATMENT PROVIDER WORKS WITH PROBATION OFFICERS,* how many probation officers do you work with on your current caseload of sex offenders? ____**

***Q18. IFTREATMENT PROVIDER WORKS WITH PAROLE OFFICERS,* how many parole officers do you work with on your current caseload of sex offenders? ____**

DEPENDING ON WHETHER THE TREATMENT PROVIDER WORKS WITH PROBATION/PAROLE OR BOTH, ASK ONE OR BOTH SETS OF QUESTIONS BELOW

NOTE: If provider works with both, let them know you will be asking the next set of questions separately about the probation officers and parole officers they work with.

Q19. Do the PROBATION officers you work with typically send you PSIRs for s offenders they supervise?

1 Yes, always or almost always
2 Yes, at least half the time but not always
3 Yes, but less than half the time
0 Never or very seldom

***Q19A. If never or very seldom*, do you request a copy of the PSIR?**

1 Yes
0 No

Q19B. Do you receive copies of the PSIR after you make the request?

1 Yes, always or almost always
2 Yes, at least half the time but not always
3 Yes, but less than half the time
0 Never or very seldom

Q20. Do the PAROLE officers you work with typically send you PSIRs for sex offenders they supervise?

1 Yes, always or almost always
2 Yes, at least half the time but not always
3 Yes, but less than half the time
0 Never or very seldom

Q20A. ***If never or very seldom*****, do you request a copy of the PSIR?**

1 Yes
0 No

Q20B. Do you receive copies of the PSIR after you make the request?

1 Yes, always or almost always
2 Yes, at least half the time but not always
3 Yes, but less than half the time
0 Never or very seldom

Q21. Do the PROBATION officers send you other information about the sex offender?

1 Yes

If yes, what types of information do you usually receive?**(Q21A-F)**

1 Police Report
2 Confidentiality Agreement
3 Copy of the supervision plan
4 Notification of a change in supervising officers
5 Other:_____
6 Other:_____

0 Never or very seldom

<u>If Never or very seldom</u>, what else would be useful? **(Q21G-I)**

2 I don't need anything else

Q22. Do the PAROLE officers send you other information about the sex offender?

1 Yes

If yes, what types of information do you usually receive? **(Q22A-F)**

1 Police Report
2 Confidentiality Agreement
3 Copy of the supervision plan
4 Notification of a change in supervising officers
5 Other:_____
6 Other:_____

0 Never or very seldom

<u>If Never or very seldom</u>, what else would be useful? (**Q22G-I)**

2 I don't need anything else

Typically, how often do you talk to the (PROBATION/PAROLE) officer(s) about a specific offender?

Q23A. Typically talk to PROBATION officers	*Q23B. Typically talk to PAROLE officers*
1 Between daily and weekly 2 More than monthly but less than weekly (*e.g., 2-3 times a month)* 3 Monthly 4 Ever couple of months 5 Never 6 For specific situations *(depends on offender, when offender is "high risk", as needed, for deception)* 7 Varies (probe for more information, e.g., when do you and when do you not talk to probation officers)_____ _____ 8 Other:	1 Between daily and weekly 2 More than monthly but less than weekly (*e.g., 2-3 times a month)* 3 Monthly 4 Ever couple of months 5 Never 6 For specific situations *(depends on offender, when offender is "high risk", as needed, for deception)* 7 Varies (probe for more information, e.g., when do you and when do you not talk to probation officers)_____ _____ 8 Other:

Do you make a note in the file when you contact PROBATION/PAROLE officer(s)?	
Q24A. For PROBATION	**Q24B. For PAROLE**
1 Always 2 Sometimes 0 Never	1 Always 2 Sometimes 0 Never

Do you provide PROBATION/PAROLE officer(s) with WRITTEN progress reports regarding offenders on your caseload?			
Q25A. For PROBATION		**Q25B. For PAROLE**	
0	No	0	No
4	Provide updates through phone calls. How often?	4	Provide updates through phone calls. How often?
3	Sometimes, depends on officer. How often?	3	Sometimes, depends on officer. How often?
2	Sometimes. How Often?	2	Sometimes. How Often?
1	Yes. How Often?	1	Yes. How Often?

IF THEY RECEIVE PROGRESS REPORTS ASK Q__ AND COMPLETE THE TABLE BELOW, AND ASK IF THIS APPLIES TO PROBATION, PAROLE OR BOTH, AS APPROPRIATE.

What types of information do you typically provide about the offender in progress reports? ***DO NOT READ (Probe "anything else")***

If the respondent indicates that s/he provides a "generic check list" or "updates," find out what is typically included. If the respondent works with both parole and probation officers, you may need to probe only once to see if they simply provide the same types of reports to both.

(***enter a 1 if mentioned)***

PROBATION	***PAROLE***	
Q26A.1	Q26B.1	Treatment **ATTENDANCE**
Q26A.2	Q26B.2	Treatment **PARTICIPATION**
Q26A.3	Q26A.3	Treatment **PROGRESS**
Q26A.4	Q26B.4	Treatment **PLAN UPDATES**
Q26A.5	Q26B.5	Treatment **COMPLIANCE**
Q26A.6	Q26B.6	Treatment **LEVEL CHANGES**
Q26A.7	Q26B.7	Increased/Decreased **RISK**
Q26A.8	Q26B.8	New/Updated **EVALUATIONS** (pyschosexual and risk)
Q26A.9	Q26B.9	**VIOLATIONS**
Q26A.10	Q26B.10	Following **RULES**/or not
Q26A.11	Q26B.11	**POLYGRAPH** results
Q26A.12	Q26B.12	**POLY OR PLETHYS** scheduled
Q26A.13	Q26B.13	Other **TEST RESULTS**
Q26A.14	Q26B.14	General: **How they've been doing**
Q26A.15	Q26B.15	**SEX HISTORY** Information
Q26A.16	Q26B.16	Other (describe)
Q26A.17	Q26B.17	
Q26A.18	Q26B.18	

See S & G 5.310 for circumstances where provider should contact the supervising officer

Other than progress reports under what circumstances do you contact a PROBATION and PAROLE officers about an offender on your caseload?

DO NOT READ (probe--anything else? You will need to probe to determine whether the response applies to probation, parole or both, as appropriate) Place a "1" in boxes to the left if mentioned; OTHERWISE, LEAVE BLANK

PROBATIONON	PAROLE	
Q27.1	Q26B.1	Offender **violates provider/client contract, including specific conditions of probation, parole or community corrections**
Q27A.2	Q26B.2	Evidence or likelihood of an **offender's increased risk** of re-offending
Q27A.3	Q26A.3	When there is a **reduction in frequency or duration of contacts**
Q27A.4	Q27B.4	When there is a **change in treatment modality**/treatment plan
Q27A.5	Q27B.5	When offender is **not complying** with treatment
Q27A.6	Q27B.6	To discuss/inform about **employment issues**
Q27A.7	Q27B.7	To discuss/inform about **housing issues**
Q27A.8	Q27B.8	To discuss **payment for services**
Q27A.9	Q27B.9	To discuss/inform about **offender's progress in treatment**
Q27A.10	Q27B.10	Offender could be **danger to self or others**
Q27A.11	Q27B.11	To discuss/inform about **new disclosures of victims**
Q27A.12	Q27B.12	To discuss inform/ about **new disclosures of behaviors**
Q27A.13	Q27B.13	To **provide information REQUESTED BY the supervising officer**
Q27A.14	Q27B.14	When arranging **contacts between the offender and a child victim**
Q27A.15	Q27B.15	When there are plans for **family reunification**
Q27A.16	Q27B.16	To discuss **visitation supervisors** for an offender's contact with children
Q27A.17	Q27B.17	To discuss the results of **polygraphs.**
Q27A.18	Q27B.18	Other, describe:
Q27A.19	Q27B.19	Other, describe:
Q27A.20	Q27B.20	Other, describe:
Q27A.21	Q27B.21	Other, describe:
Q27A.22	Q28B.22	Other, describe

See section 5.200 for Supervising officer responsibilities

Under what circumstances does the PROBATION OFFICER contact (including emails, faxes, etc.) you ?

DO NOT READ (prompt--anything else?)

Insert a"1" if probation officer contacts the tx provider in this situation. **If "1" Ask question in second column.**	What percent of the probation officers that you **currently** work with contact you in this situation (enter actual percentage, e.g, 30%, 10%)?	
Q28A	Q28A.1	To **refer** an offender for evaluation/treatment
Q28B	Q28B.1	To **discuss/inform about** results of **polygraphs**
Q28C	Q28C.1	To discuss/inform about behavioral **monitoring**
Q28D	Q28D.1	To **arrange team conferences/staffings**
Q28E	Q28E.1	To **obtain** copies of the **treatment plan/monthly reports or other information**
Q28F	Q28F.1	To **obtain a risk assessment** or information about offender risk
Q28G	Q28G.1	To **get updates** about the offender
Q28H	Q28H.1	To **discuss plans for contacts with children**
Q28I	Q28I.1	To discuss **family reunification**
Q28J	Q28J.1	To report about **contact with victim**
Q28K	Q28K.1	To report contacts with **potential victims**
Q28L	Q28L.1	To discuss **specific incidents**
Q28M	Q28M.1	To discuss **disclosures**
Q28N	Q28N.1	To discuss **offender leaving the state or traveling**
Q28O	Q28O.1	To talk before the **polygraph**
Q28P	Q28P.1	To **request than an offender be terminated from treatment** (if this is noted ask why that would occur)
Q28Q	Q28Q.1	If the **offender were to be violated or revoked**
Q28R	Q28R.1	General: **Get information/check in**
Q28S	Q28S.1	Other, describe:
Q28T	Q28T.1	Other, describe:
Q28U	Q28U.1	Other, describe:
Q28V	Q28V.1	Other, describe:
Q28W	Q28W.1	Other, describe:

Under what circumstances does the PAROLE OFFICER contact (including emails, faxes, etc.) you ?

DO NOT READ (prompt--anything else?)

Insert a"1" if probation officer contacts the tx provider in this situation. **If "1" Ask question in second column.**	What percent of the probation officers that you **currently** work with contact you in this situation (enter actual percentage, e.g, 30%, 10%)?	
Q29A	Q29A.1	To **refer** an offender for evaluation/treatment
Q29B	Q29B.1	To **discuss/inform about** results of **polygraphs**
Q29C	Q29C.1	To discuss/inform about behavioral **monitoring**
Q29D	Q29D.1	To **arrange team conferences/staffings**
Q29E	Q29E.1	To **obtain** copies of the **treatment plan/monthly reports or other information**
Q29F	Q29F.1	To **obtain a risk assessment** or information about offender risk
Q29G	Q29G.1	To **get updates** about the offender
Q29H	Q29H.1	To **discuss plans for contacts with children**
Q29I	Q29I.1	To discuss **family reunification**
Q29J	Q29J.1	To report about **contact with victim**
Q29K	Q29K.1	To report contacts with **potential victims**
Q29L	Q29L.1	To discuss **specific incidents**
Q29M	Q29M.1	To discuss **disclosures**
Q2N	Q29N.1	To discuss **offender leaving the state or traveling**
Q29O	Q29O.1	To talk before the **polygraph**
Q29P	Q29P.1	To **request than an offender be terminated from treatment** (if this is noted ask why that would occur)
Q29Q	Q29Q.1	If the **offender were to be violated or revoked**
Q29R	Q29R.1	General: **Get information/check in**
Q29S	Q29S.1	Other, describe:
Q29T	Q29T.1	Other, describe:
Q29U	Q29U.1	Other, describe:
Q29V	Q29V.1	Other, describe:
Q29W	Q29W.1	Other, describe:

Do you think that you have an adequate amount of contact with PROBATION/PAROLE officer(s) regarding sex offenders on your caseload?	
Q30A.CONTACT WITH PROBATION	**Q30B. CONTACT WITH PAROLE**
1 Yes 2 Somewhat 0 No If no or somewhat, what would be better?	1 Yes 2 Somewhat 0 No If no or somewhat, what would be better?

Do you and the probation officer discuss sanctions and decide together what sanctions to invoke for treatment or supervision non-compliance?

Q31A. PROBATION	**Q31B. PAROLE**
1 Yes 0 No	1 Yes 0 No

"THIS NEXT SECTION IS ABOUT HOW POLYGRAPH EXAMINERS FIT INTO YOUR WORK REGARDING SEX OFFENDERS"

Q32. How many polygraph examiners do you work with on your current caseload of sex offenders? __ __

Q33. Do you receive copies of the polygraph reports from the polygraph examiner?

1 Yes, always or almost always
2 Yes, more than half the time but not always
3 Yes, less than half the time
0 Never or seldom

Q34A-C. How do you use the results of the polygraph?

_____

_____

Q35. How often do you talk to polygraph examiners about offenders on your caseload?

1 Between daily and weekly
2 More than monthly but less than weekly (*e.g., 2-3 times a month)*
3 Monthly
4 Less than monthly
5 Never
6 For specific situations *(depends on offender, when offender is "high risk", as needed, for deception)*
7 Varies (probe, e.g., when do you and when do you not talk to polygraph examiners):_____
_____
8 Don't Know

Q36. Do you have input into the question content for the polygraph exam?

1 Always or most always (Is this useful, why?) (Q36A.1-3)
_____
2 Sometimes (Is this useful, why?) (Q36B.1-3)
_____
0 Never or seldom (Is there a reason?) (Q36C.1-3)
_____

Q37. Do you talk to polygraph examiners about offenders on your caseload?

1 Yes (probe: under what circumstances/when does this happen, etc?) (Q37A1-3)
_____
3 Sometimes **(probe: under what circumstances/when does this happen, etc?) (Q37B1-3)**
_____
0 No **(probe about possible reasons:) (Q37C1-3)**
_____

Q38. Do you think the polygraph is useful or detrimental, or some of both in supervising and monitoring sex offenders?

1 The polygraph is useful

If the respondent thinks the polygraph is useful, find out why? If response is something like "can better manage" try to get more specific information. (DO NOT READ, insert a 1 for all positive responses, leave the remaining blank)

	To determine **compliance (**Q38A)
	To get **sex history/learn more about disclosures/victims(**Q38B)
	To gain **insight about the offender** (Q38C)

	To address **denial** (Q38D)
	To address **specific situations (**e.g., high risk, suspicions) (Q38E)
	To learn more about offender's **risk of re-offending** (Q38F)
	To keep them "honest"/promotes honesty (Q38G)
	Other:
	(Q38H)
	(Q38I)
	(Q38J)
	(Q38K)

0 **Respondent thinks polygraph is detrimental.** (*Probe, why?)*

Q39A-C. How did you select the polygraph examiner?

_____

_____

Q40. Do you work with the offender to prepare him/her for the polygraph exam?

0 No

1 Yes

<u>If Yes</u>, how? (Q40A-C)

Q41. Are you satisfied with the polygraph services that are available to you?

1 Yes

0 No

<u>If No</u>, why? (Q41A-C)

"NOW I'D LIKE TO ASK A FEW QUESTIONS ABOUT CONSEQUENCES AND SANCTIONS USED WITH AN OFFENDER"

Q42. Do you sanction or impose consequences when an offender has deceptive polygraph results?

1 Yes

4 Depends or sometimes *(probe for reasons:)* **(Q42A.1-3)**

IF YES OR DEPENDS/SOMETIMES, what types of sanctions or consequences do you impose for deceptive polygraphs? (Q42B.1-3)

0 No

Q43. Do you sanction or impose consequences when an offender has inconclusive polygraph results?

1 Yes

2 Depends or sometimes *(probe for reasons:)* **(Q43A.1-3)**

IF YES OR DEPENDS/SOMETIMES, what types of sanctions or consequences do you impose for inconclusive polygraphs? (Q43B.1-3)

0 No

In what *<u>other</u>* types of situations do you sanction or impose consequences on an offender?

List the situations	***What types of sanctions/consequences are imposed for this situation?***
Q44A.1 TO Q44A.5	Q44B.1 TO Q44B.5

"NOW I WOULD LIKE TO ASK SOME QUESTIONS ABOUT THE SUPERVISION AND TREATMENT TEAM AND HOW DECISIONS ARE MADE"

Typically, who is included as part of the supervision and treatment team for the sex offenders you manage? *DO NOT READ RESPONSES, BUT Probe: Is anyone else TYPICALLY included?*

(insert a 1 for all mentioned)

	Supervising Officer (Q45A)
	Polygraph Examiner (Q45B)
	Victim Advocate/Therapist (Q45C)
	Other: (Q45D)
	Other: (Q45E)
	Other: (Q45F)

Q46. Typically, do ALL the team members meet as a group to discuss specific cases?

1 Yes

Q46A. Do you meet over the phone or in person?

1 Phone
2 In Person
3 Both

Q46B. How often do you typically meet as a team on offenders?

_____
_____

Q46C. Do you think team meetings occur often enough?

1 Yes
0 No

Q46D.1-3. **IF NO, what would be more helpful?**

2 **SOME** of the team members meet.

Q46E. Which team members typically meet?

_____
_____

Q46F.1-3 Why do some team members meet and not others?

_____
_____

Q46G. Do you meet over the phone or in person?

1 Phone
2 In Person
3 Both

Q46H. How often do these team members meet to discuss offenders?

_____
_____

Q46I. Do you think team meetings occur often enough?

1 Yes
0 **Q46J.1–3** No. What would be more useful?

0 NO, typically team members do not meet.

Q46K.1-3. Why is that?

_____

_____

Q46L.1-3. IF NO, do you and team members have other ways to share information? What?

_____

_____

Q47. Are certain DECISIONS about an offender always or almost always made by the <u>entire team</u>, that is (*list all the people the respondent has mentioned in Q23)*

1 Yes

2 Sometimes

IF YES OR SOMETIMES, what types of decisions are team decisions?

Q47A. __Contact with children (*Check if they mention contact with childre*n)

Q47B._____

Q47C._____

Q47D._____

0 No

IF NO

Typically, which decisions are NOT made by the entire team?

Insert 1	Decision	Who makes the decision
	Contact with children Q47E	**Q47E.1**
	Q47F	**Q47F.1**
	Q47G	**Q47G.1**
	Q47H	**Q47H.1**
	Q47I	**Q47I.1**

IF THE RESPONDENT <u>HAS NOT ALREADY ADDRESSED</u> DECISION MAKING PROCESS REGARDING CONTACT WITH CHILDREN, ASK Q48. OTHERWISE MOVE TO Q49.

Q48. Who makes the decision about contact with children (as an exception to the conditions of supervision)?

(If respondent indicates that the team makes this decision, and the Polygraph examiner is a member of the team, verify that the PE is included in the decision about contact with children.)

_____
_____
_____

Q49. If a child victim has an advocate or a therapist, is this person involved in decisions to allow offender contact with the victim?

0 No
1 Yes, how? **(Q49A-C)**

_____
_____

2 Most children do not have an advocate or therapist

Q50. Are any of the offenders you currently supervise permitted contact with children?

0 No, ***PROCEED TO Q51***

1 Yes ***continue with the questions on this page***

Q50A. How many offenders of the offenders that you currently supervise are permitted contact with children?__ __

Q50B. Are restrictions associated with this contact?
0 No
1 Yes
2 Sometimes

Q50C1-3. IF YES or SOMTIMES, what are these restrictions associated with contact with children?

_____
_____

Q50D.1-3. For offenders you supervise who have contact with children, what types of are permitted?

_____
_____

Q50E.1-3 How was the decision made or for what reasons were these offenders permitted contact with children?

_____
_____
_____

Q50F.1-3 Are there additional provisions to the treatment/supervision of the offenders who have contact with children that address monitoring this contact? (probe what are they?)

_____
_____
_____

Q50G. Do offenders who are permitted contact with children meet the SOMB criteria for contact with children?

Note: The researcher should be thoroughly familiar with this section of the Standards and Guidelines.

1 Yes

Q50G.1 IF YES, is this typically documented in the file?

0 No *(note any comments the respondent may have, e.g., we discuss over the phone, but no formal documentation)*
(Q50G.1a-c)

_____
_____
_____

1 Yes. How? **(Q50H.1a-c)**

_____
_____
_____

1 No

Q50I. Of the offenders currently on your caseload who have contact with children, are any of these children known victims of the offender?

0 No
9 Don't Know
1 Yes

Q50J. IF YES, do these victims want contact with the offender?

1 Yes
2 Some do, some don't
0 No

"I HAVE A FEW MORE QUESTIONS ABOUT THE TEAM"

Q51. Do the sex offender teams you work with experience conflict?

0 No

1 Yes. What causes conflict? **(Q51A.1-3)**

2 Some do, some don't. What causes conflict? **(Q51B.1-3)**

Q51C. IF YES OR SOME, have you developed successful ways to resolve conflict?

5 No

6 Yes. What are they? What would be useful to others in the same situation? **(Q51C.1-3)**

Q52. What, if any, are the pluses about a team approach to managing and treating the sex offenders?

Q53. What, if any are the minuses about a team approach to managing and treating sex offenders?

"THE LAST FEW QUESTIONS IN THIS SECTION REFER TO THE SOMB STANDARDS AND GUIDELINES"

Q54. Have you ever been to a SOMB monthly meeting?

1 **<u>If Yes</u>, how many?__ __(Q54A)**

0 **No**

Q55. Have you ever been on a SOMB subcommittee?

1 **<u>If Yes</u>, how many?_____(Q55A)**

Which ones?

_____(Q55B-D)

0 **No**

Q56. Are there problems or barriers to implementing the SOMB Standards and Guidelines?

2 No

3 Yes. What are they? **(Q56A-C)**

Q57. Have you found ways to overcome these problems and barriers?

0 No.

What has gotten in the way of trying to overcome these problems? **(Q57A.1-3)**

1 Yes. What were they? **(Q57B.1-3)**

Q58A-C. Which standards, if any, should be reconsidered? Why?

Q59 Do you think there are important issues that are not covered or are not adequately covered by the standards?

0 No

1 Yes. Which issues? **(Q59A-C)**

Q60. Do you think that the Standards and Guidelines are useful?

1 No. Why not? **Q60A.1-3**

1 Yes. Why? **Q60B.1-3**

Q61. Do you feel as if you have had input into the process of developing the standards?

2 No. Is there a particular reason why you feel you have not had input? (Q61A.1-3)

3 Yes. How have you had input? (Q61B.1-3)

Q62. Do you have suggestions for how the SOMB could be more effective in implementing the standards?

2 No

3 Yes. What are they? Q62A.1-3

DCJ TREATMENT PROVIDER ID __ __ __

Polygraph Examiner -Telephone Survey #1

Name of Polygraph Examiner:

Survey #1 X Yes	**Administer to all polygraph examiners**
Survey #2 ___ ___ Yes No **Qsurvey2.**	**Did you polygraph sex offenders in Colorado Communities before the development of the Standards and Guidelines (before 1996)?** **How long have you been polygraphing sex offenders? (Interviewer, please code in months (__ __ __) Qtime.**

Use the introduction that describes the surveys to be administered (USE ONLY ONE):

Introductions:

Check appropriate box for this provider	
❑ **Survey #1**	***"I'd like to ask you some questions about your work with sex offenders and the other members of the sex offender treatment and supervision team. The interview should take about …"***
❑ **Surveys #1, #2**	***"First I'd like to ask you some questions about your work with sex offenders and other members of the sex offender management team. Then I'd like to ask a few questions in regard to the standards and guidelines and changes you may have perceived since their initial implementation. The interview should take about …"***

"FIRST I'D LIKE TO ASK YOU A COUPLE OF GENERAL QUESTIONS"

Q1YRS.Q1MOS. **How long have you been working with sex offenders? (years__ __, months__ __)**

Q2COYRS, Q2COMOS. How long have you been working with sex offenders in <u>Colorado</u>?(years__ __, months__ __)

Q3. Have you participated in the American Polygraph Association's 40 hour training on sex offender testing?

1 Yes
0 No.

Q4. Do you feel like you have an adequate amount of training to do the post conviction polygraph with sex offenders?

1 Yes
1 No. What would be useful?

Q5. Have you ever attended the monthly SOMB meetings?

2 Yes, how many times? _____
2 No

Q6. Have you ever served on any of the SOMB sub-committees?

3 Yes, which?_____ _____ _____
0 No

"THE FOLLOWING QUESTIONS ARE ABOUT HOW YOU EXCHANGE INFORMATION WITH THE OFFENDER'S TREATMENT PROVIDER"

Q7. In general, how often do you talk to the treatment provider about specific cases?

(DO NOT READ RESPONSES, but circle as many as apply--try to get somewhat specific responses. For instance, if the respondent says "all the time," try to narrow that down. If s/he says "sometime a lot and sometimes never," try to find out in which situations the respondent speaks to the therapist frequently, and in which situations they never speak. Then try to code the responses in the following categories: add others if necessary)

1 Between daily and weekly
2 More than monthly but less than weekly (*e.g., 2-3 times a month)*
3 Monthly
4 Every couple of months
5 Never
6 For specific situations *(depends on offender, when offender is "high risk",as needed, for deception)*
7 Varies (probe, e.g., when do you and when do you not talk to therapists:_____
_____
8 Other:_____
9 Other:_____

Q8. Do you think that you have an adequate amount of contact with the treatment provider?

4 Yes
2 Somewhat
0 No

<u>IF NO OR SOME,</u> what would be better?

Q9. For what reasons DO YOU contact a treatment provider?

DO NOT READ (*probe - - anything else?)*

Place a "1" here if mentioned; OTHERWISE LEAVE BLANK	
	Offender tried to manipulate the polygraph
	Offender had new disclosures
	Offender failed the polygraph
	Offender needed different type of polygraph
	Offender was not prepared for the polygraph
	Offender had physical/mental conditions that prevented them from doing the polygraph
	Payment for the polygraph
	Report behaviors encountered during the polygraph exam
	Scheduling of polygraph exams
	To discuss the results of the polygraph exam
	Other, describe:
	Other, describe:
	Other, describe:

Q10. Do you send copies of the polygraph report to the treatment provider?

1 Yes, always or almost always
2 Yes, more than half the time but not always
3 Yes, less than half the time
0 Never or seldom

Q11. What type of information is included in this polygraph report?

DO NOT READ *(probe - - anything else?)*

Place a "1" here if mentioned; OTHERWISE LEAVE BLANK	
	Date of test or evaluation
	Name of person requesting exam
	Location of examinee in the criminal justice system (probation, parole, etc)
	Reason for examination
	Date of last clinical examination
	Examination questions and answers
	Any additional information deemed relevant by the Polygraph examiner, eg examinee's demeanor
	Reasons for inability to complete exam, information from examinee outside the exam, etc
	Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee
	Test questions
	Other, describe:
	Other, describe:

Q12. Does the treatment provider give you input into the question content for the polygraph exam?

1 Always or most always (Is this useful, why?) _____

2 Sometimes (Is this useful, why?) _____

0 Never or seldom (Is there a reason?)_____

"THE FOLLOWING QUESTIONS ARE ABOUT HOW YOU EXCHANGE INFORMATION WITH THE OFFENDER'S SUPERVISING OFFICER"

Q13. In general, how often do you talk to the supervising officer about specific cases?

(DO NOT READ RESPONSES, but circle as many as apply--try to get somewhat specific responses. For instance, if the respondent says "all the time," try to narrow that down. If s/he says "sometime a lot and sometimes never," try to find out in which situations the respondent speaks to the therapist frequently, and in which situations they never speak. Then try to code the responses in the following categories: add others if necessary)

1 Between daily and weekly
2 More than monthly but less than weekly (*e.g., 2-3 times a month)*
3 Monthly
4 Every couple of months
5 Never
6 For specific situations *(depends on offender, when offender is "high risk",as needed, for deception)*
7 Varies (probe, e.g., when do you and when do you not talk to therapists:_____
_____
8 Other:_____
9 Other:_____

Q14. Do you think that you have an adequate amount of contact with the supervising officer?

5 Yes
2 Somewhat
0 No

<u>IF NO OR SOME,</u> what would be better?

Q15. For what reasons DO YOU contact a supervising officer?

DO NOT READ (*probe - - anything else?)*

Place a "1" here if mentioned; OTHERWISE LEAVE BLANK	
	Offender tried to manipulate the polygraph
	Offender had new disclosures
	Offender failed the polygraph
	Offender needed different type of polygraph
	Offender was not prepared for the polygraph
	Offender had physical/mental conditions that prevented them from doing the polygraph
	Payment for the polygraph
	Report behaviors encountered during the polygraph exam
	Scheduling of polygraph exams
	To discuss the results of the polygraph exam
	Other, describe:
	Other, describe:
	Other, describe:

Q16. Do you send copies of the polygraph report to the supervising officer?

1 Yes, always or almost always
2 Yes, more than half the time but not always
3 Yes, less than half the time
0 Never or seldom

Q17. Does the supervising officer give you input into the question content for the polygraph exam?

1 Always or most always (Is this useful, why?)
_____
2 Sometimes (Is this useful, why?) _____
0 Never or seldom (Is there a reason?)_____

Q18. Do you think the offenders you polygraph are adequately prepared for the exam by the treatment provider and the P.O.?

1 Yes
2 Sometimes
3 No, what would help?

"NOW I WOULD LIKE TO ASK SOME QUESTIONS ABOUT THE SUPERVISION AND TREATMENT TEAM AND HOW DECISIONS ARE MADE"

Q19. Typically, who is included as part of the supervision and treatment teams?
1 Yes
0 No, Why?

Q19a. Typically, who (or who else) is included as part of the supervision and treatment teams? DO NOT READ RESPONSES, BUT PROBE: Is anyone else typically included? (Note: If PE is not part of the team he may not know the answer to these questions.)

Place a "1" here if mentioned; OTHERWISE LEAVE BLANK	
	Don't Know (Proceed to Q21)
	Therapist
	Supervising Officer
	Other:
	Other:

Q20. Typically, do ALL the team members meet or have a phone conference as a group to discuss specific cases?

9 DK

1 Yes

Q20PHONE. Does the team meet over the phone or in person?

1 Phone

2 In Person

3 Both

Q20OFTEN. How often does the team typically meet as a team on offenders?

_____

_____

Q20ENOU. Do you think team meetings or phone conferences occur often enough?

1 Yes

0 No

IF NO, what would be more helpful?

2 **SOME** or **NO**, typically team members do not meet or phone each other.

Q20WHY. Why is that? DON'T READ

___ Don't need to

___ No time/too busy

___ Lack of preparation by other team members

___ The examiner is not really treated as part of the team

___ Other

Q20SHARE. IF SOME or NO, do you and team members have other ways to share information? What?

_____

_____

Q21. What, if any, are the pluses about a team approach to managing and treating the sex offenders?

Q22. What, if any are the minuses about a team approach to managing and treating sex offenders?

"THE LAST FEW QUESTIONS IN THIS SECTION REFER TO THE SOMB STANDARDS AND GUIDELINES"

Q23. Are there problems or barriers to implementing the SOMB Standards and Guidelines?

4 No
5 Yes. What are they?

Q24. Have you found ways to overcome these problems and barriers?

0 No. What has gotten in the way of trying to overcome these problems?

1 Yes. What were they?

Q25. Which standards, if any, should be reconsidered? Why?

Q26. Do you think there are important issues that are not covered or are not adequately covered by the standards?

0 No
1 Yes. Which issues?

Q27. Do you feel as if you have had input into the process of developing the standards?

4 No. Is there a particular reason why you feel you have not had input?

5 Yes. How have you had input?

Q28. Do you have suggestions for how the SOMB could be more effective in implementing the standards?

4 No

5 Yes. What are they?

APPENDIX C:

DATA COLLECTION INSTRUMENTS

DCJ ID __ __ __ OFFENDER NAME _____ Jurisdiction/Site Location_____
(PLEASE USE PENCIL SO IT CAN BE ERASED)

FIELD RESEARCHER ASSISTANCE IN LOCATING INFORMATION IN THE SUPERVISING OFFICER DATA FORM

Tag the following if contained in THE SUPERVISING OFFICER file	In file: 1=yes 0=no	Discussed on this page of collection form
MENTAL HEALTH SEX OFFENSE SPECIFIC EVALUATION		**5**
REGISTRATION		**6**
TREATMENT PLAN		**6**
PROVIDER PROGRESS REPORTS		**8**
RELAPSE PLAN		**8**
SEX HISTORY		**8**
RELEASES OF INFORMATION (FOR TX PROVIDER AND PE)		**16**

TABLE OF CONTENTS - KEEP IN MIND THE FOLLOWING TOPIC AREAS WHEN READING HARD AND ELECTRONIC NOTES

♦Compliance to sentencing requirements, supervision conditions and treatment directives.

SUPERVISING OFFICER DATA COLLECTION FORM - HARD COPY

Note:

- ***Also asked in the last 6 months, or in the last year or two, we will be looking from October 22, 2002 back. The reason for this is because that is the day the sample was pulled.***
- ***For any questions that require a date, if a date cannot be determined put 88-88-88.***
- ***Whenever you cannot determine something put an 8***
- ***When you have a situation when there are numerous violations, contacts, etc. put 77.***
- ***If you have an individual who was convicted of a sex offense and given probation and then it was revoked and re-granted you want to take the original conviction as the current offense.***

Demographics:

AGE AT CURRENT OFFENSE: __ __

Date of Birth

Sex
1-Male
2-Female

Dependents

Marital Status
1-Single
2-Married
3-Sep/Div
4-Widowed
5-Common Law

Ethnicity
1-Anglo/White
2-African American
3-Hispanic
4-Am Indian
5-Asian
6-Other

Education Last Grade
0-11=Actual Grade
12=HS Diploma
13=Some College
14=College Degree
15=Some Graduate
16=Graduate Degree
17=GED

Employment at: Arrest / Sentence
1-Full time (40+ hours)
2-Part time
3-Unemployed
4-Sporadic
5-AFDC/SSI/Disability
6-Student
7-Retired

Job Type: At arrest / At Sentence
01-Manual labor
02-Fast Food Restaurant
03-Non fast food restaurant
04-Manufacturing/Factory
05-Sales (store clerk, service stat)
06-Sales (professional)
07-Clerical
08-Entry level work
09-Skilled/Experienced work (Vocational)
10-Specialized work (4 yrs college)
11-Professional/Expert (4+yrs)
12-Military

NOTE:

For demo info, we want to be recording info at time of *offense*, unless otherwise noted. If the offense ranges in dates take the first date.

For Employment: If you have marked Unemployed, AFDC, Student, or Retired at Job Type put 00's.

Stability (During the 2 yrs before Arrest for this case)
1-Continuously resided at same address
2-Has moved 1, 2, 3 times
3-Has moved 4+ times
4-Transient

Record of Abuse as a child
0-No
1-Yes , sexual abuse
2-Yes, other abuse

Record of Substance Use as juvenile
0-None
1-Drugs
2-Alcohol
3-Both

Note: If they charged or convicted of a misdemeanor in Felony Class mark 9

Offenses Charged:

1st Most Serious:

5=Attempt
6=Accessory
7=Conspiracy

Counts | Fel Class

Offense: _____

Total Counts Charged:

Total # of Victims Pertaining to Instant Case:

Offenses Convicted:

1st Most Serious:

5=Attempt
6=Accessory
7=Conspiracy

Counts | Fel Class

Offense: _____

Total Counts Convicted:

Date of Conviction/Sentencing:
MO __ __ DAY __ __ YR __ __

Total # of Victims Convicted of:

Note: If you have both the Conviction and Sentencing date, take the Conviction date. Also circle either conviction or sentencing to tell us which one used.

Under Supervision at Time of Offense?
0=No
1=Probation
2=ISP
3=Parole
4=Work Release
5=Other

Guiding Principle 2. Sex offenders are dangerous
Guiding Principle 3. Community safety is paramount.

CRIMINAL HISTORY-UP TO *BUT NOT* INCLUDING THE CURRENT OFFENSE (Sexual Assault)

NOTE:
Record only what the judge would know.
Make 9=Don't Know

Juvenile History (0-7=actual #, 8=8or more)

Arrests
- ☐ Violent
- ☐ Non-Violent

Juvenile Convictions
- ☐ Violent
- ☐ Non-Violent
- ☐ Misdemeanor
- ☐ Felony
- ☐ Probation/parole supervisions
- ☐ Probation/parole revocations
- ☐ Placements in shelter/group homes
- ☐ Commitments to state institutions

Age at 1st Arrest ☐☐

Adult History (0-7=actual #, 8=8 or more)

Arrest
- ☐ Violent
- ☐ Non-Violent

Adult Convictions
- ☐ Violent
- ☐ Non-Violent
- ☐ Misdemeanor
- ☐ Felony

Supervisions/Incarcerations
- ☐ Prison
- ☐ Parole
- ☐ ComCor
- ☐ Jail
- ☐ Probation
- ☐ DJ

Revocations
- ☐ Parole
- ☐ CC
- ☐ Probation
- ☐ DJ

Sex Crimes (Juvenile and Adult)

JUVENILE
- ☐ Arrests

CONVICTIONS
- ☐ Misd
- ☐ Felony

ADULT
- ☐ Arrests

CONVICTIONS
- ☐ Misd
- ☐ Felony

Age at 1st Arrest for a *Sex Crime*? (ADULT OR JUV) ☐☐

Any Prior Adult Felony Convictions or Juvenile Adjudications for Any of the Following Offenses?
Enter actual # of convictions/adjudications.

- ☐ Theft
- ☐ Sex Offense (last 5 years)
- ☐ Forgery or Bad Checks
- ☐ Other Violent offense
- ☐ Auto Theft
- ☐ Sex Offense (5+ years)
- ☐ Murder/Manslaughter
- ☐ 1st deg burg
- ☐ Robbery
- ☐ Assault (last 5 years)
- ☐ Kidnapping
- ☐ 2nd or 3rd deg burg
- ☐ Drug Offense
- ☐ Assault (5+ years)
- ☐ Menacing

QC02. Date offender began supervision for the CURRENT OFFENSE: mo___day___yr___

Note: Gather the following victim and offense information on each offender from the PSIR, Police Report and other file information UP TO and including the current crime (this is what the judge would have)

Age Group **QV1 TO QV8**	**Gender** **1=male** **2=female** **3=both** **QV1GEN TO QV8GEN**	**Relationship** **1=family** **2=pos/trust** **3=acquaint** **4=stranger** **(insert as many as apply)** **QCV1REL-QV8REL**	**Penetration Offense (includes oral and anal as well as attempts)** **1=yes** **0=no** **QV1MPEN-QV8MPEN** **QV1FPEN-QV8FPEN**		**Fondling/ Frottage** **1=yes** **0=no** **QV1MFON-QV8MFON** **QV1FFON-QV8FFON**		**Other** **1=yes** **0=no** **QV1MOTH-QV8MOTH** **QV1FOTH-QV18OTH**		**For Other Insert types of behaviors, use numbers from (*) UP TO 5** **QV1PAR1-23 TO QV8PAR1-23**	**At the offense offender was** **1=juvenile** **2=adult** **3=juv and adult** **4=not available** **QV1OFF-QV8OFF**
			male	female	male	female	male	female		
0-5										
6-9										
10-13										
14-17										
18+										
Eld/Risk										
Unknown										
Not against persons										

(*) A list of behaviors will be provided so the field research can insert the number rather than write out the behavior

Age of victim(s) current offense **__ __, __ __, __ __, __ __**
QAGE_CV1 QAGE_CV2 QAGE_CV3 QAGE_CV4

QREL_A0-9V If there is a child victim *prior to the current offense* within an offender's family, what is the offender's relationship to the victim? (Circle all that apply)

0 No child victim
1 Child(ren)
2 Stepchild(ren)
3 Adopted Child(ren)
4 Sibling
5 Niece
6 Nephew
7 Cousin
8 Grandchild
9 Cannot determine

QREL_B0-9. If there is a child victim *during the current offense* within an offender's family, what is the offender's relationship to the victim? (Circle all that apply)

0 No child victim
1 Child(ren)
2 Stepchild(ren)
3 Adopted Child(ren)
4 Sibling
5 Niece
6 Nephew
7 Cousin
8 Grandchild
9 Cannot determine

PRE-SENTENCE INVESTIGATION REPORT (PSIR)

1.010 *Each sex offender should be the subject of pre-sentence investigation, including a mental health sex offense specific evaluation, prior to sentencing, even when by statute it is otherwise acceptable to waive the pre-sentence investigation.*

QPSIR1. Is there a PSIR in the PO file?

1 Yes: Date -- mo ___day ___ yr ___

0 No

QPSIR2. Was there a Sex Offense Specific Mental Health Evaluation in the file?

0 No

1 Yes

If Yes, Date of SO MH Eval: mo___day___yr___(Pick first date if evaluation conducted over several days/weeks)

QPSIR3. Was the evaluation found in the PSIR?

0 No

1 Yes

1.040 A pre-sentence investigation (PSI) report should address the following: (items are listed below)

Please note whether the PSIR and/or the MH SO Evaluation addresses the following:

0 = not addressed
1 = addressed adequately
2 = addressed minimally
8 = not applicable

Note: Mark both if mentioned in the PSIR as well as the MH SO eval.

Note: If no MH SO EVAL, leave blank

	PSIR	MH SO Eval
QPSIR4A & QPSIR4B. residence		
QPSIR5A & QPSIR5B criminal history		
QPSIR6A & QPSIR6B. education history		
QPSIR7A & QPSIR7B. employment history		
QPSIR8A & QPSIR8B financial status		
QPSIR9A & QPSIR9B leisure/recreation activities		
QPSIR10A & QPSIR10B companions		
QPSIR11A & QPSIR11B victim impact addressed/incorporated in recommendations		
QPSIR12A & QPSIR12B potential impact of sentencing on the victim(s)		
QPSIR13A & QPSIR13B emotional and personal problems		
QPSIR14A & QPSIR14B. family, marital and relationship issues		
QPSIR15A& QPSIR15B Offense/assault patterns		
QPSIR16A & QPSIR 16B victim grooming behaviors		
QPSIR17A & QPSIR 17B drug/alcohol problems		
QPSIR18A & QPSIR18B. attitude at time of interview and during process		
QPSIR19A & QPSIR19B. Criminal Orientation		

QPSIR21. Is there a separate victim impact statement?

1 yes
0 no
8 cannot determine

SUPERVISING OFFICER - ICON

QPSIR22. If no PSIR, does the Hard File, ICON, or the Minutes indicate that a judge ordered a PSIR?

1 Yes
0 No
8 Cannot determine
9 There is a PSIR

Note:

- ***Those convicted of 1st, 2nd, 3rd degree Sexual Assault, Sexual Assault on a Child, or Sexual Assault in a Position of Trust (including accessory, conspiracy, and accessory) should have a DCJ/SOMB Risk Assessment in their file.***
- ***Usually this score can be found in Part 3 of the Sexually Violent Predator Risk Assessment Screening Instrument***

QRISK1. Is there a DCJ/SOMB Risk Assessment in the File?

1 Yes: Score (0-10) _____
0 No

REGISTRATION

5.216 The supervising officer should notify sex offenders that they must register with local law enforcement in compliance with Section 18-3-412.5 C.R.S.

QREG1. Does the file show that the supervising officer notified the offender that he/she must register?

1 Yes
0 No
2 Doesn't have to register

TREATMENT PLAN

QTX1. Is there a copy of the treatment plan in the supervising officer's file?

1 Yes
0 No

When was the treatment plan done? Month ___ Day___ Year ___ (ENTER 88s IF DATE UNKNOWN) QTXPLMO QTXPLDA QTXPLYR

DENIAL

3.650 Offenders who are still in strong or severe denial and/or are strongly resistant after this six (6) month phase of treatment shall be terminated from treatment and revocation proceedings should be initiated if possible. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if revocation is not an option....

QDENIAL1. At the start of treatment was this offender in denial (see treatment plan and MH SOS evaluation)?

8 Cannot determine
0 No
1 Yes

QDENIAL2. If the offender was in denial at the start of treatment, was the offender offered treatment to address the issue of denial (specific deniers' treatment)?

8 Cannot determine
0 No
1 Yes

QDENIAL3. If yes, the offender was offered treatment did s/he attend?

8 Cannot determine
0 No
1 Yes
2 Attended some of the time

QDENIAL4.After six months from the start of treatment was the offender in denial?

1 Yes
0 No
8 Cannot determine

Note: Date of treatment may have been recorded in the hard copy file information.

QDENIAL5. If yes, did revocation proceed at the end of the six months?

1 Yes
0 No
If No, Why not?

8 Cannot determine

QDENIAL6. Was the offender ever revoked?
1= Yes What Happened?
0 = No
8 =Can not determine

QDENIAL7. Were sanctions/consequences imposed by the supervising officer for denial at *the end of six months* or *throughout the six-month period* that the offender was in denial?

1 Yes
If yes, what were they?

0 No
8 Cannot determine
9 Not Applicable

QDENIAL5. Was monitoring increased during this period of denial?

1 Yes
0 No
8 Cannot determine
9 Not applicable

How was monitoring increased (circle all that apply?

1 QDENIAL6. home detention
2 QDENIAL7. electronic monitoring
3 QDENIAL8 Other: (DESCRIBE:)
4 QDENIAL9. Other: (DESCRIBE:)

RELAPSE PLAN/SAFETY PLAN

5.240 The supervising officer should require sex offenders to provide a copy of the written plan developed in treatment for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising officer should utilize the relapse prevention plan in monitoring offenders' behavior.

QRELAP1. Is there a copy of the relapse or safety plan in the supervising officer's file that addresses safety /relapse issues for the offender?

1 Yes
0 No
2 An incomplete relapse plan is in the file; it appears the offender has not yet progressed to the point of developing a complete relapse plan.

Note: If there have been any safety plans for specific events,etc.: _____
_____

SEX HISTORY QUESTIONNAIRE

QSH1. Is there a thorough sex history questionnaire in the file?

1 Yes
0 No
2 A sex history has been started but the offender has not yet completed it.

PROVIDER PROGRESS REPORTS

5.310 D. *On a timely basis, and no less than monthly, a provider shall provide to the supervising officer progress reports documenting offenders' attendance, participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress.*

QPROG1. Does the supervising officer file contain monthly progress reports from the provider for the last six months?

1 Yes
0 No
2 Some, but not monthly (How many in the last six months? __ __)
QPROG1B.

Looking at the provider monthly progress reports for the last SIX MONTHS, do they discuss the following:

Note: If the reports vary, put an average response		**Codes:** **1=YES, BUT NO DETAILS** **2=YES WITH DETAILS** **3=SOMETIMES** **0=NO**
QPROG2. offender's attendance in treatment		
QPROG3. offender' participation in treatment		
QPROG4. increase in risk factors		
QPROG5. changes in treatment plan		
QPROG6. treatment progress		
QPROG7. living arrangements		

QLIV1. What is the offender's current living arrangement?

1 Shared Living Arrangement
2 With their family of origin
3 With own children
4 With stepchildren
5 Alone
6 With roommate
7 Other, Describe:_____
8 Cannot determine

TREATMENT/SUPERVISION TEAM

5.110 *As soon as possible after the conviction and referral of a sex offender to probation, parole or community corrections, the supervising officer should convene a team to manage the offender during his/her term of supervision.*

QTEAM1. Are the CURRENT members of the Treatment/SupervisionTeam (minimally the therapist, the supervising officer and the polygraph examiner) identified in the file?

1 Yes
0 No

5.120 *Each team, at a minimum should consist of: the supervising officer, the offender's treatment provider, and the polygraph examiner.*

Record the names of the CURRENT team members *(those people who meet regularly)* below:	
QTEAM2. Probation Officer	**QTEAM2A.**
QTEAM3 Treatment Provider	**QTEAM3A.** **Address:** **Phone Number:**
QTEAM4. Polygraph Examiner	**QTEAM4A.**
QTEAM5. Other:	**QTEAM5A.**
QTEAM6. Other:	**QTEAM6A.**
QTEAM7. Other:	**QTEAM7A.**

Note: For this we are looking for REAL SUBSTANTIVE COMMUNICATION, making sure that a conversation did exist

QTEAM8. Is there documentation that the team (at least the officer, tx provider, and PE) has convened *in person*?

2 Cannot determine if there is a team
0 No
1 <u>If Yes</u>, date of the first meeting: mo __ __ day __ __ yr__ __
QTEAMMO QTEAMDA QTEAMYR

QTEAM9. What is the total number of times met in the last six months? __ __

QTEAM10. Is there documentation that the team (at least the officer, tx provider and PE) has convened *on the phone or over email*?

2 Cannot determine if there is a team
0 No
1 Yes
<u>If Yes</u>, date of the first communication: mo __ __day __ __ yr__ __
QTMO QTDAY QTYR

QTEAM11. What is the total number of communications within the last six months? __ __

QTEAM 12. Is there evidence in the file that the *supervising officer* and *treatment provider* have VERBALLY discussed the offender in the last six months?

1 Yes, how many times:__ __(QTEAM13)
0 No
8 Cannot determine

QTEAM14. Is there evidence in the file that the *supervising officer* and *polygraph examiner* have VERBALLY discussed the offender in the last six months?

1 Yes, how many times:__ __ (QTEAM15)
0 No
8 Cannot determine

Describe the TEAM as well as any other supervisor (i.e. D&A, Anger Mgmt Counselor, etc) contact with this offender: _____
_____
_____
_____
_____
_____

QTEAM16, QTEAM17, QTEAM18, QTEAM19 (use up to 3 codes)

COLLABORATION WITH VICTIM ADVOCATE, PARENTS, GUARDIAN AD LITEM

5.710 A. *Whenever possible, collaborate with an adult victim's therapist or advocate, or a child victim's therapist, guardian, custodial parent, foster parent, and/or guardian ad litem, in making decisions regarding communication, visits, and reunification.*

Note: This only pertains to the VICTIM

QADVOC1. Is there documentation of 5.710 A. in the file IN THE LAST YEAR?

1 Yes, there is regular (at least <u>monthly with at least one</u> of the above) communication
<u>If yes</u>, who was contacted _____
_____

2 Some contact, <u>at least once and less frequently than monthly</u>
<u>If some contact</u>, who contacted:_____

0 No, there is no evidence of contact with any of those listed in 5.710 A.

5.600 Behavioral Monitoring of Sex Offenders in the Community

5.610 The monitoring of offenders' compliance with treatment and sentencing requirements shall recognize sex offenders' potential to re-offend, re-victimize, cause harm, and the limits of sex offenders' self-reports:

5.610 A. Responsibility for behavioral monitoring activities shall be outlined under explicit agreements established by the supervising officer. Some or all members of the team described in Section 5.00 will share monitoring responsibility. At a minimum, the provider, the supervising officer, and the polygraph examiner shall take an active role in monitoring offenders' behaviors.

5.230 The supervising officer, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring....

5.213 On a regular basis, the supervising officer should review each offender's specific conditions of probation, parole or community corrections and assess the offender's compliance, needs, risk, and progress to determine the necessary level of supervision and the need for additional conditions.

5.260 The supervising officer should ensure maximum behavioral monitoring y and supervision for offenders in denial. The officer should use supervision tools that place limitations on offenders' use of free time and mobility and emphasize community safety and containment of offenders.

Note: To do this section, please write out the non-compliant issue and then select the numbers from the list on how they learned about the area of non-compliance and what sanctions were applied.

Areas of non-compliance documented in the *LAST YEAR*	**# of times this non-compliance happened:** **1=Once** **2= 2-6 times** **3=6 or more**	**How did they learn about this non-compliance:** **(Use the List)**	**What sanctions were applied:** **(Use the List)**	**How often were these sanctions applied:** **1=Always** **2=Never** **3=Sometimes** **8=Cannot Determine**
QBH1.				
QBH2.				
QBH3.				
QBH4.				
QBH5.				
QBH6.				
QBH7.				
QBH8.				
QBH9.				

QBH10.				
QBH11.				
QBH12.				
QBH13.				
QBH14.				
QBH15.				
QBH16.				
QBH17.				
QBH18.				
QBH19.				
QBH20.				
QBH21.				
QBH22.				
QBH23.				
QBH24.				
QBH25.				
QBH26.				
QBH27.				
QBH28.				
QBH29.				
QBH30.				

INCREASED RISK

5.610 B. Behavioral monitoring should be increased during times of an offender's risk to re offend, including but not limited to, such circumstances as the following.

Did the file document that the offender experienced the following situations IN THE LAST YEAR? If so, did monitoring change?

*Indicate **how often the supervising officer responds** with monitoring in this type of situation. (This is **not** an indicator of how often the offender experiences the situation.) **Write in monitoring response, e.g., electronic monitoring.***

The offender experienced stress or a crisis. **0=No** **1=Yes, how many times in the last year __ __** **If Yes, Describe:**	**Monitoring Response: (write in)** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring/no stress or crises noted**
The offender was in a high-risk environment. **0=No** **1=Yes, how many times in the last year __ __** **If Yes, Describe:**	**Monitoring response:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring/not in high risk environment**
Visits between the offender and victims or potential victims (recommend and approved). **0=No** **1=Yes, how many times in the last year__ __** **If Yes, Describe:**	**Monitoring response:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring/no visits**
Offender demonstrated high or increased level of denial. **(Anything above their original level of denial)** **0=No** **1=Yes, how many times in the last year __ __** **If Yes, Describe:**	**Monitoring response:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring/not in denial**
Offender had access to potential victims. **0=No** **1=Yes, how many times in the last year__ __** **If Yes, Describe:**	**Monitoring response:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring**

Other (specify): **0=No** **1=Yes, how many times in the last year__ __**	**Monitoring Methods:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring**
Other (specify): **0=No** **1=Yes, how many times in the last year __ __**	**Monitoring Methods:** **Always 5 4 3 2 1 Never** **8 Can't determine** **6 No indication of need to increase monitoring**

TERMS AND CONDITIONS - AND VIOLATIONS

5.610 3. For purposes of compliance with this standard, behavioral monitoring activities shall include, but are not limited to: the use of support of targeted limitations on an offenders behavior, including those conditions set forth in 5.500

5.500 Conditions of community supervision

5.510 Special conditions

DOES THE FILE CONTAIN EVIDENCE THAT THE OFFENDER HAS BEEN NOTIFIED *(through formal documentation or by other means)* OF THE FOLLOWING TARGETED LIMITATIONS ON HIS OR HER BEHAVIOR?	**1=yes 0=no 8=Can't determine 9=Not Applicable**
QTC1. Offender notified of no contact with any victim	**1 0 8 9**
QTC2. Offender notified of no contact with any child under age 18	**1 0 8 9**
QTC3. Cannot befriend or date anyone with children under 18	**1 0 8 9**
QTC4. Cannot access or loiter near school yards, parks, etc., other places used primarily by children (unless approved in advance and in writing by the supervising officer)	**1 0 8 9**
QTC5. Cannot be employed or volunteer for any activity involving contact with children (unless approved).	**1 0 8 9**
QTC6. Not allowed possession or viewing of pornography, sexually oriented or sexually simulating materials, or patronizing place where this type of material or entertainment is available (except for that used in treatment).	**1 0 8 9**
QTC7. Cannot consume or possess alcohol or drugs	**1 0 8 9**
QTC8. Residence and living situation must be approved in advance by the supervising officer in consultation with the community supervision team.	**1 0 8 9**
QTC9. Required to undergo blood, saliva, and DNA testing	**1 0 8 9**
QTC10. Must sign information releases so all professionals involved in assessment, treatment & behavioral monitoring can communicate/share documentation.	**1 0 8 9**
QTC11. Cannot hitchhike or pick up hitchhikers	**1 0 8 9**
QTC12. Shall attend and actively participate in evaluation and treatment approved by the supervising officer and shall not change treatment providers without prior approval from the supervising officer.	**1 0 8 9**
QTC13. Shall not obtain access or use of the internet.	**1 0 8 9**
QTC14. Other:	**1 0 8 9**
QTC15. Other:	**1 0 8 9**
QTC16. Other:	**1 0 8 9**
QTC17. Other:	**1 0 8 9**
QTC18. Other:	**1 0 8 9**
QTC19. Other:	**1 0 8 9**
QTC20. Other:	**1 0 8 9**
QTC21. Other:	**1 0 8 9**
QTC22. Other:	**1 0 8 9**
QTC23. Other:	**1 0 8 9**
QTC24. Other:	**1 0 8 9**
QTC25. Other:	**1 0 8 9**

ADDITIONAL VICTIM TYPES

QAV. After reviewing the hard copy file and ICON, did you find that the offender revealed *additional* victims types (*that is, IN ADDITION to information in the PSIR and those revealed in POLYGRAPH)?* For Example, from phone calls, home visits, etc.

1 Yes
0 No
8 Cannot Determine

If the offender revealed additional victims, please complete the following*: (REMEMBER THESE ARE IN ADDITION TO ANY VICTIMS FOUND IN PSIR OR POLYGRAPH-those are recorded in separate areas)*

Age Group QAV1-QAV8	**Was offender under supervision for current offense 1=yes 0=no 8=can't tell**	**Gender 1=male 2=female 3=both 8=can't tell** **QAV1 GEN QAV8 GEN**	**Relationship 1=family 2=pos/trust 3=acquaint 4=stranger 8=can't tell (insert as many as apply)** **QAV1REL QAV8REL**	**Penetration Offense 1=yes 0=no 8=can't tell** **M= Male F=Female** **QAV1MPEN QAV8FPEN**		**Fondling/ Frottage 1=yes 0=no 8=can't tell** **QAV1FONM QAV8FONM**		**Other 1=yes 0=no 8= can't tell** **QAV1OTHF QAV8OTHM**		**For Other Insert types of behaviors, use numbers from Chart (*)** **QAV1PAR1-QAV8PAR23**	**At the offense offender was 1=juvenile 2=adult 3=juv and adult 4=not available QAV1OFF TO QAV8OFF**	**Source of information on new victim QAV1SRC TO QAV8SRC 1=Offender 2=Third party 3=Therapist 4=Other (describe)**
	QAVSUP1-8			M	F	M	F	M	F			
0-5												
6-9												
10-13												
14-17												
18+												
Eld/Risk												
Unknown												

QAVCHILD. If there is a child victim within an offender's family, what is the offender's relationship to the victim? (Circle all that apply)

0 No child victim
1 Child(ren)
2 Stepchild(ren)
3 Adopted Child(ren)
4 Sibling
5 Niece
6 Nephew
7 Cousin
8 Grandchild
9 Cannot determine

QAVCHG. If additional victims were revealed, was supervision changed?

2 No new victims revealed in file
0 No
8 Cannot determine
0 Yes
If yes, how was supervision changed?

CONTACT WITH CHILDREN

QCC1. After reviewing the supervising officer file, including the polygraph information, did you find information indicating that the offender has a history of sexual perpetration with children?

1 Yes
0 No
8 Cannot determine

QCC2. During the last TWO YEARS on probation, has the offender had contact with children under 18?

0 No
8 Cannot determine
1 Yes, if yes complete the table below:

Note: Negative consequences can mean assault, inappropriate contact, and also thoughts and fantasies about the child

	Codes: 1=yes 0=no 8=cannot determine					
The offender:	**The rationale for contact/ access to children is documented in the file.**	**What is the rationale? (CODE UP TO 3)**	**Contact /access to children approved by the team?**	**There is a safety plan that specifically addresses contact/access to children?**	**Were there negative consequences because of this access**	**If negative consequences list sanctions (if no Sanctions were applied, enter 0-LIST UP TO 4**
QCC3A. Was allowed to live with children	**QCC3B**	**QCC3C-E**	**QCC3F**	**QCC3G**	**QCC3H**	**QCC3I-L**
QCC4A. Was allowed contact with children (not pertaining to living with children)	**QCC4B**	**QCC4C-E**	**QCC4F**	**QCC4G**	**QCC4H**	**QCC4I-L**
QCC5A. Had direct contact with children that was not permitted	**QCC5B**			**QCC5G**	**QCC5H**	**QCC5I-L**
QCC6A. Had indirect contact/access with children that was not permitted (e.g., lived or worked near children)	**QCC6B**			**QCC6G**	**QCC6H**	**QCC6I-L**

COMPLETE FOR OFFENDERS WHO HAVE CONTACT WITH CHILDREN

Selected Conditions of 5.7

If the offender is currently allowed contact with children, review the Supervising Officer's file to determine whether AT THE START OF THIS CONTACT was there evidence of the following in the file:

	Evidence was found in the officer's file 1=yes, 0=no
QCC7. The offender accepts responsibility for the abuse	
QCC8. The offender has completed a non-deceptive sexual history disclosure polygraph	
QCC9. The offender has completed at least one non-deceptive maintenance polygraph	
QCC10. The treatment/supervision team has meet, discussed contact, and have approved contact	
QCC11. The child's therapist, advocate or child protective agency has been included in the decision	

FOR ALL OFFENDERS, REGARLESS OF WHETHER OR NOT THEY HAD CONTACT WITH CHILDREN

QCC12. Did the supervising officer question the offender regarding sexual/inappropriate contact with children IN THE LAST TWO YEARS?

0 No
8 Can't determine
1 Yes, if yes, how many times__ __ (code 25 if over 25 times)

QCC13

QCC14. Has the offender been questioned in the last month?

1 Yes
0 No
8 Cannot determine

QCC15. Did the victim (child or adult) REQUEST contact with the offender?

1 Yes
0 No
8 Cannot determine
9 Not applicable (no specific victim identified with the current crime)

QCC16. If, the victim (child or adult) did not request contact, and the offender is in contact with the victim, can you determine the rationale for offender victim contact.

1 Yes, what_____
_____
_____QCC23A-B (CODE UP TO 4)
0 No
7 No Contact Exists
8 Cannot determine
9 Not applicable (no specific victim identified with the current crime)

OVERALL MATCH OF MONITORING AND OFFENDER NEEDS

QMATCH1. Upon your review of the supervising officer file, does the level and intensity of behavioral monitoring OVER THE LAST SIX MONTHS match the offender's needs?

2 To a great extent
1 Somewhat
0 Not at all
8 Cannot determine because _____
_____

(QMATCH2-3) (CODE UP TO 2)

YOU MUST document your rating if you gave one. ***(Please note any positive of their monitoring as well as any areas that need improvement or are areas of concern)*****: QMATCH4-7 (CODE UP TO 4)**

_____
_____
_____
_____
_____
_____
_____
_____

OFFENDER NAME:_____
(use pencil so it can be erased).

DCJ ID __ __ __ FOR OFFENDERS IN FILE SAMPLE USE THE SAME NUMBER FOR SUPERVISING OFFICER FILE, TREATMENT PROVIDER FILE, AND TELEPHONE SURVEYS

Tag the following if contained in the TREATMENT PROVIDER FILE	In file: 1=yes 0=no	Discussed on page:
Mental Health Sex Offense-Specific Evaluation		2
Evaluator's Report		9
Confidentiality Waiver		9
Treatment Contract		10
Treatment Plan		11
Relapse Plan		17

MH SOS Evaluation	2
Confidentiality Waiver	9
Plethysmograph	9
Abel Screen	9
Evaluator's Report	9
Treatment Contract	10
Treatment Plan	11
Treatment Plan Reflects MH SO Evaluation	12
Treatment Plan Goals and Objectives	14
Services Received	15
Relapse Plan	17
Treatment Plan Matches Offender Needs	17
Treatment Plan Updates	14
Denial	18

Treatment Provider File
Mental Health Sex Offense-Specific Evaluation

Note: The following information refers to the Mental Health Sex Offense Specific Evaluation which may or may not have been developed by the provider. However, the report should be in the treatment provider file.

2.010 In accordance with Section 16-11-102(1)(b) C.R.S., each sex offender shall receive a mental health sex offense-specific evaluation at the time of the pre-sentence investigation.

Note: For any questions that require a date, if a date cannot be determined put 88-88-88.

TMHSO1. Does the treatment provider file include a Mental Health Sex Offense-Specific Evaluation?

1 Yes
0 No

Date of MH SOS Evaluation Mo___Day ___Year ___(TMHSOMO, THMSODA,THMOSAYR)

2.070 *Unless otherwise indicate below, the following evaluation modalities are all required in performing a mental health offense -specific evaluation:*

Examination of criminal justice information, including the details of the current offense and documents that describe victim trauma, when available
Examination of collateral information, including information from other sources on the offender's sexual behavior
Structured clinical and sexual history and interview
Offense-specific psychological testing
Standardized psychological testing if clinically indicated
Medical examination/referral for assessment of pharmacological needs if clinically indicated
Testing of deviant arousal or interest through the use of the penile plethysmograph or the Abel Screen
Also, 2.090 and 2.120 3.610 *Level of Denial and defensiveness shall be assessed during the mental health sex offense-specific evaluation.*

TTOOL1-65. Please circle all assessment tools found in the file used in the MHSO Specific Evaluation

1	**WAIS-R**	**33**	**Weschler Memory Scale**
2	**WAIS III**	**34**	**Limbic System Checklit**
3	**WRAT-R Revised Beta**	**35**	**Structure Mental Status Exam**
4	**TONI (Test of Non-Verbal Intelligence**	**36**	**History of Functioning**
5	**Shipley Institute of Living Scale**	**37**	**Structured Interview**
6	**MMPI or MMP12**	**38**	**Jacobs Cognitive Screening Test**
7	**MCMI-II or III**	**39**	**Quick Neurological Screening Test**
8	**Beck Depression Scale**	**40**	**Medical Tests**
9	**CAC (Clinical Analysis Questionnaire**	**41**	**Collateral Information**
10	**PHQ (Personal History Questionnaire)**	**42**	**Treatment history**
11	**ADS**	**43**	**FES (Family Environment Scale)**
12	**DAST-20**	**44**	**DAS (Dyadic Adjustment Scale)**
13	**Adult Substance Use Survey (ASUS)**	**45**	**MSI (marital Satisfaction Inventory**
14	**Substance Use History Matrix (SUHM)**	**46**	**IBS (Interpersonal Behavior Survey)**
15	**HARE Psycopathy Checklist Revised**	**47**	**Social Avoidance and Distress Scale**
16	**MDP Measures of Psychological Development**	**48**	**Waring'sIntimacy Scale**
17	**COI California Personality Inventory**	**49**	**UCLA Loneliness Scale**
18	**PSCI (Personal Sentence Completion Inventory)Miccio-Fonseca**	**50**	**Tesch's Intimacy Scale**
19	**Wilson Sexual Fantasy Questionnaire**	**51**	**Miller's Social Intimacy Scale**
20	**SONE (Sexual History Background Form)**	**52**	**Attitude towards Women Scale**
21	**SORI (Sex Offender Risk Instrument)**	**53**	**Socio-Sexual Knowledge and Attitudes Test (for use with sex offenders who have developmental disabilities**
22	**MSI Multiphasic Sex Inventory**	**54**	**Polygraph**
23	**Sexual Autobiography**	**55**	**DCJ Risk Scale**
24	**Plethysmograph**	**56**	**SOMB Checklist**
24	**Abel Screen**	**57**	**Oregon Risk Assessment Scale**
26	**Clarke**	**58**	**Violence Assessment Risk Guide**
27	**Bentler Heterosexual Inventory**	**59**	**Rapid Risk Assessment for Sex Offender Re-arrest**
28	**Abel and Becker Card Sort**	**60**	**MnSOST-R Risk Assessment**
29	**Burt Rape Myth Acceptance Scale**	**61**	**Sonar**
30	**Abel and Becker Cognition Scale**	**62**	**Static 99**
31	**Kaufman IQ test for Adults**	**63**	**Other:**
32	**Standord Binet**	**64**	**Other:**

Note: Determine whether the MH SO Evaluation contains the areas of assessment noted on the LEFT. It is unlikely that the entire evaluation will be in the file. The techniques for evaluation are listed on the right to help the researcher determine references to possible areas of assessment.

Evaluation Areas Required	**Problem Areas**	**Possible Evaluation Procedures**
Evaluation Area Completed	***From the evaluations was it determined that it was a problem for the offender***	***Circle the assessment procedures if you can determine that it was used for this portion of the evaluation***
TEVAL1. IQ Functioning *(Mental Retardation, Learning Disability, and Literacy)* 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL1A. 1= Yes 0= No 8= Can't determine	History of Functioning WAIS-R or WAIS III WRAT-R-Revised Beta TONI (Test of Non-Verbal Intelligence) Shipley Institute of Living Scale Revised Kaufman IQ Test for Adults Stanford Binet
TEVAL2. Organic Brain Syndrome (OBS) 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL2A. 1= Yes 0= No 8= Can't determine	History of Functioning WAIS-R Weschler Memory Scale Revised Limbic System Checklist Structured Mental Status Exam Jacobs Cognitive Screening Test Quick Neurological Screening Test Medical Tests Necessary for Diagnosis
TEVAL3. Mental Illness 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL3A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview MMPI or MMPI2 MCMI-II or III Beck Depression Scale
TEVAL4. Alcohol and Drug Use/Abuse 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL4A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview MMPI CAQ (Clinical Analysis Questionnaire) PHQ (Personal History Questionnaire) ADS DAST-20 Adult Substance Use Survey Substance Use History Matrix Collateral Information
TEVAL5.Number of D/A Relapses 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL5A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview Treatment History Collateral Information
EVALUATE CHARACTER PATHOLOGY		
TEVAL6. Degree of Impairment 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL6A. 1= Yes 0= No 8= Can't determine	Hare Psychopathy Checklist Revised (PCLR or PCLSC) Structured Interview MCMI-II or III History Collateral Information

EVALUATE STABILITY OF FUNCTIONING		
TEVAL7. Marital/Family Stability (past, current, familial violence	TEVAL7A.	History of Functioning and/or Structured Interview

familial sexual, financial housing) 1= Yes 0 = No 2 = Partial 8 = Can't determine	1= Yes 0= No 8= Can't determine	FES (Family Environment Scale) DAS (Dyadic Adjustment Scale) MSI (Marital Satisfaction Inventory) Interview Attitudes Collateral Information
TEVAL8. Employment/Education (completion of major life tasks) 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL8A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview PHQ (Personal History Questionnaire)
TEVAL9. Social Skills (ability to form and maintain relationships, courtship/dating skills, ability to demonstrate assertive behavior) 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL9A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview Collateral Information IBS (Interpersonal Behavior Survey) Social Avoidance and Distress Scale Waring's Intimacy Scale UCLA Loneliness Scale Tesch's Intimacy Scale Miller's Social Intimacy Scale
DEVELOPMENTAL		
TEVAL10. (Disruptions in parent/child relationship, history of bed wetting, cruelty to animals, hx of behavior problems in elementary school, special education services, learning disabilities, school achievement, disordered attachments.) 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL10A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview Collateral Information
EVALUATION OF SELF		
TEVAL 11. Self-image, Self Esteem, Ego Strength 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL11A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview MPD (Measures of Psychological Development) CAQ (Clinical Analysis Questionnaire) CPI (California Personality Inventory)
MEDICAL SCREENING MEASURES		
TEVAL 12. Pharmacological Needs Medical Condition Impacting Offending Behavior History of Medication Use/Abuse 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL12A. 1= Yes 0= No 8= Can't determine	History of Functioning and/or Structured Interview Referral to Physician if indicated Medical Tests

SEXUAL EVALUATION

TEVAL13. Sexual History *(Onset, Intensity, Duration, Pleasure Derived)* Age of Onset of Expected Normal Behaviors Quality of First Sexual Experience Age of Onset of Sexually Deviant Behaviors Witnessed or Experienced Victimization as a Child (Sexual or Physical) Genesis of Sexual Information Age/Degree of Use of Pornography, Phone Sex, Cable, Video, or Internet for Sexual Purposes Current and Past Range of Sexual Behavior 1= Yes 0 = No 2 = Partial 8 = Can't determine		History of Functioning and/or Structured Interview Collateral Information PSCI (Personal Sentence Completion Inventory--Miccio-Fonseca) Wilson Sexual Fantasy Questionnaire SONE Sexual History Background Form SORI (Sex Offender Risk Instrument – in research stage)
TEVAL14. Reinforcement Structure for deviant behavior (who are they living with, where, friends, etc.) Culture Environment Cults 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL14A. 1= Yes 0= No 8= Can't determine	Structured Interview
TEVAL15. Arousal Pattern (sexual arousal, interest) 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL15A. 1= Yes 0= No 8= Can't determine	Plethysmograph Abel Screen
TEVAL16. ***Specifics of Sexual Crime(s)*** *(Onset, Intensity, Duration, Pleasure Derived)* Detailed Description of Sexual Assault Seriousness, Harm to Victim Mood During Assault (Anger, Erotic, "Love") Progression of Sexual Crimes Thoughts Preceding and Following Crimes Fantasies Preceding and Following Crimes 1= Yes 0 = No 2 = Partial 8 = Can't determine		Structured Interview History of Crimes Collateral Information Review of Criminal Records Review of Victim Impact Statement Contact with Victim Therapist Polygraph
TEVAL17. Sexual Deviance 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL17A. 1= Yes 0= No 8= Can't determine	Structured Interview MSI (Multiphasic Sex Inventory) SONE Clarke

TEVAL18. Dysfunction *(Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning,Etc.)* 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL18A. 1= Yes 0= No 8= Can't determine	Structured Interview MSI (Multiphasic Sex Inventory) Sexual Autobiography
TEVAL19. Offender's Perception of Sexual Dysfunction 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL19A. 1= Yes 0= No 8= Can't determine	Structured Interview Sexual Autobiography Bentler Heterosexual Inventory Abel and Becker Card Sort History
TEVAL20. Preferences *(Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors)* 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL20A. 1= Yes 0= No 8= Can't determine	Structured Interview Sexual Autobiography Plethysmograph Able Screen
TEVAL21.Attitudes/Cognition *Motivation to Change/Continue Behavior* *Attitudes Toward Women, Children, Sexuality in General* 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL21A. 1= Yes 0= No 8= Can't determine	Structured Interview Burt Rape Myth Acceptance Scale MSI (Multiphasic Sex Inventory) Buss/Durkee Hostility Inventory Abel and Becker Cognitions Scale
TEVAL22. Attitudes About Offense (i.e., Seriousness, Harm to Victim) *Degree of Victim Empathy* *Presence/Degree of Minimalization* *Presence/Degree of Denial* *Ego-syntonic vs. Ego-dystonic Sense of Deviant Behavior* 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL22A. 1= Yes 0= No 8= Can't determine	Attitudes Towards Women Scale Socio-Sexual Knowledge and Attitudes Test (For use With sex offenders who have developmental disabilities)
EVALUATE LEVEL OF DENIAL AND/OR DECEPTION		
TEVAL23. Level of Denial *Level of Deception* 1= Yes 0 = No	TEVAL23A. 1= Yes 0= No 8= Can't determine	Structured Interview * Collateral Information (such as from victim, police, others) Polygraph

2 = Partial 8=Can't Determine		DCJ Risk Scale

EVALUATE LEVEL OF VIOLENCE AND COERCION		
TEVAL24. Level of violence, pattern of assaults, victim selection, escalation of violence 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL24A. 1= Yes 0= No 8= Can't determine	Structured Interview History Collateral Information Review of Criminal Records
EVALUATE RISK		
TEVAL25. Risk of Re-offense 1= Yes 0 = No 2 = Partial 8 = Can't determine	TEVAL25A. 1= Yes 0= No 8= Can't determine	Criminal History DCJ Sex Offender Risk Scale (Actuarial scale normed on Colorado offenders from probation, parole and prison) SOMB Checklist (Normed on Colorado Offenders from probation, parole and community corrections) Oregon Risk Assessment Scale (Normed on Oregon offenders) Violence Risk Assessment Guide (Normed on a psychiatric hospital sample) Rapid Risk Assessment for Sex Offender Re-Arrest (Sample excludes incest offenders) MnSOST-R (Normed on Minnesota Offenders in the Department of Corrections, excludes incest offenders) Sonar Static 99 Other_____ Did not use instrument; clinical opinion

EVALUATOR'S REPORT

2.110 *The evaluator shall recommend (listed below)*

TEVAL0-9. The evaluation report indicates that the evaluator has covered the following (CIRCLE ALL THAT APPLY)

0 **No evaluator Report in the Treatment Provider File**
1 **Offense-specific treatment**
2 **A referral was made for medical/pharmacological treatment if indicated**
3 **Treatment of co-existing problems (e.g., drug abuse, anger management)**
4 **Appropriate external controls (work environment, leisure time, life stresses, etc.)**
5 **Methods to lessen victim impact**

6 **Appropriateness of community placement**
7 **No contact with children**
8 **No contact with defendant's children**
9 **Other, explain:**

CONFIDENTIALITY WAIVER

3.210 A treatment provider shall obtain signed waivers of confidentiality based on the informed assent of the offender

Note: If there isn't a separate Confidentiality waiver, but it is part of the treatment contract consider it a YES

TCON1. Is a signed waiver of confidentiality in the file?

1 **Yes**
0 **No**

PLETHYSMOGRAPH

TPLETH1. Did the offender undergo a plethysmograph?

1 **Yes**
0 **No**
8 **Cannot determine**

ABEL SCREEN

TABEL1. Was the offender administered an Abel Screen?

1 **Yes**
0 **No**
8 **Cannot determine**

TREATMENT CONTRACT

3.310 A provider shall develop and utilize a written contract with each sex offender....

TTC1. Is there a contract (OR SEPARATE DOCUMENT ADDRESSING THE FOLLOWING ISSUES) in the file?

1 **Yes, date of treatment contract: Mo___Day___Yr___ (TCMO, TCDA,TCYR)**
0 **No**

	1=Yes 0=No 8=CD= (Can not Deter) TTCA	Violations in LAST 6 MOS 1=Yes, 0=No 8=CD TTCB	Sanctions imposed for violations (from sheet) CD=88 (code up to 4) TTCC-F
DOES THE CONTRACT EXPLAIN THE FOLLOWING?			
TTC2A-F. Costs of assessment, evaluation, etc.		[redacted]	
TTC3A-F. Waivers of confidentiality required for treatment.			
TTC4A-F.Right to refuse treatment, refuse to waive confidentiality, and risks of that decision.			
TTC5A-F. Type, frequency, duration and **requirements of treatment.**			
TTC6A-F. Describe **limits of confidentiality** per 19.3-304 CRS			
DOES THE CONTRACT EXPLAIN RESPONSIBILITIES OF A CLIENT TO			
TTC7A-F.Pay the cost of assessment and treatment for him or herself and his or her family			
TTC8A-F. Pay to cost of assessment and treatment for victim and family when court ordered			
TTC9A-F. Inform his or her family/support system of details of past offenses to ensure protection of past victims.			
TTC10A-F.Actively involve relevant family/support system			
TTC11A-F.Notify the treatment provider of any changes or events in his/her life and lives of family support system.			
TTC12A-F.Participate in polygraph testing and if indicate plethysmographic testing.			
TTC13A-F. Assent to be tested for STD and HIV, and assent for results to be released to victim.			
TTC15A-F. Comply with limitations and restrictions per terms and conditions of probation, parole, or community corrections etc			
DOES THE CONTRACT ALSO:			
TTC16A-F. Provide instructions and limitations regarding contact with victims, secondary victims and children			
TTC17A-F.Describe limits or prohibitions on the use of viewing sexually explicit or violent material			
TTC18A-F.Describe the responsibility of the client to protect community safety by avoiding risky behaviors, situations and reporting any such behavior to the provider and supervising officer ASAP.			
TTC19A-F.Describe limitations and prohibitions on the use of alcohol /drugs.			
TTC20A-F.Describe limitations on employment and recreation.			

Note: Many of these might overlap with probation or parole terms and conditions, if so make sure you pinpoint the area, i.e contact with children put under 16, etc.

TREATMENT PLAN

3.130 *A provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender.*
3.140 D. *A provider shall employ treatment methods that are supported by current professional research and practice: give priority to the safety of*
an offfender's victim(s) and the safety of potential victims and the community.
3.150 Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Colorado state law on health care records. Client files shall: Document

the goals of treatment, the methods use, the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations and consequences should be records. Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.

TTX1. Is there a treatment plan in the file?

No

10 Yes

If Yes, what is the date of *original* treatment plan:
mo __ __ day __ __ year__ __(TTPMO TTPDA TTPYR)

What is the date of the *current* treatment plan:
mo __ __ day __ __ year__ __(TTPCMO TTPCDA TTPCYR)

Remember if can't find a date put 88-88-88

Note: Do Not Take the Intake Date. Take the date that they actually began treatment (1 on 1, group, etc).

Date Offender began treatment: mo __ __ day __ __ year __ __
(TTXMO TTXDA TTXYR)

Date Offender began treatment with current provider:
mo __ __ day __ __ year__ __ (TTXCURMO TTXCURDA TTXCURYR)

8 TTX2. Did the offender change treatment providers, IN THE LAST TWO YEARS?

1 Yes, why?_____
TTX2A-B (Code 2 answers)

0 No

8 Cannot Determine

TTX3A-3E.Who initiated the change in treatment providers? (Circle all that apply)

1 Treatment Provider
2 Probation Officer
3 Parole Officer
4 Offender
5 Other: _____

TTX4. Has the provider prepared an INDIVIDUALIZED written treatment plan for the offender?

8 Cannot determine
2 Somewhat
1 Yes
0 No

Note: Individualized means the treatment addresses specific issues of the offender that were based on the needs and risks identified in current/past assessments/evaluations of this offender.

TTX5. IF NO, is there a STANDARDIZED description of the program modules/phases that specifies what the offender will do for treatment?

8 Cannot determine
1 Yes
0 No

Note: Standardized means there is a program with specific modules/phases, and it appears that all offenders receive the same or mostly the same treatment. The program specifies things such as the offender will attend Sex History Group, Victim Empathy Group, etc.

Does the treatment plan or standardized description of the program address the following areas: (3.130)	**1=yes, specific and thorough** **2=yes, but vague, general or language not necessarily specific to the**

	offender (e.g., boilerplate). Or not thorough. 0=no
TTX6. Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender	
TTX7. Identify offender issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment	
TTX8. Define expectation of the offender, his/her family (when possible), and support systems	
TTX9. Address the issue of ongoing victim input	

TREATMENT PLAN/PROGRAM DESCRIPTION REFLECTS MH SO EVALUATION

Note: To complete the following table, refer to the MHSO Evaluation section you completed previously. Some of the MHSO Evaluation areas are abbreviated on the left side of the table (first column) and the question number is referenced, e.g. TEVAL. Determine whether any of these areas were IDENTIFIED AS A PROBLEM OR ISSUE FOR THE OFFENDER and complete the second column accordingly. In the last column rate how the Treatment Plan or Standardized program description addresses the offender's problem. Write a sentence to support your rating. For instance, victim input is an issue that should be addressed in all plans. If the victim input statement is simply attached to the plan, this would be rated as "minimal". If specific suggestions of the victim or victim's advocate are incorporated into treatment the rating would be "adequate". If the offender does not have a treatment plan, but the provider uses a standard program description, try to determine if any of the offenders issues are addressed with the program modules, groups, phases, etc. For instance the offender may have drug and alcohol issues, and may be required to complete a drug and alcohol group. Depending on the information on the program, you may Note: If no treatment plan, then leave this section blank ***the program language is vague and you cannot de specific issue, use a 3 for your rating.***

Evaluation areas from MH SOS Evaluation	**Was the evaluation area identified as a problem in the MH SOS Evaluation or other assessment?** **0=NO (addressed but not a problem** **1=YES (addressed and identified as a problem)** **2=Not addressed in MH SOS Evaluation or other assessment or cannot determine if it was addressed** **8=Cannot Determine**	**Is the issue addressed in the Treatment Plan or Standardized Program Description?** **0= no** **1=adequately (document your rating)** **2=minimally (document your rating)** **3=issue appears to be addressed through program, but cannot rate adequate or minimal. Not enough information.** **8=Cannot Determine**	
		Rating (0 to 3)	**Sentence or two to document rating (Code up to two reasons)**
TTP1.Contact with Children **should be addressed in all tx plans**		**TTP1B**	**TTP1C-D**
TTP2.Victim Input **should be addressed in all tx plans**		**TTP2B**	**TTP2C-D**

TTP3mpact of the offense on the victim should be addressed in all tx plans		**TTP3B**	**TTP3C-D**
TTP4Protection of Victims/Potential Victims should be addressed in all tx plans		**TTP4B**	**TTP4D-C**
TTP5Org brain Syndrome (SEE TEVAL2A)	**TTP5A**	**TTP5B**	**TTP5C-D**
TTP6. MENTAL Illness (SEE TEVAL3A)	**TTP6A**	**TTP6B**	**TTP6C-D**
TTP7. Drug Use/Abuse (SEE TEVAL4A)	**TTP7A**	**TTP7B**	**TTP7C-D**
TTP8. Marital/Family Problems (SEE TEVAL7A)	**TTP8A**	**TTP8B**	**TTP8C-D**
TTP9.Employment (SEE TEVAL8A)	**TTP9A**	**TTP9B**	**TTP9C-D**
TTP10. Education (SEE TEVAL8A)	**TTP10A**	**TTP10B**	**TTP10C-D**
TTB11. Social Skills (SEE TEVAL9A)	**TTP11A**	**TTB11B**	**TTB11C-D**
TTP12. Medication Needs (SEE TEVAL12A)	**TTP12A**	**TTP12B**	**TTP12C-D**
TTP13. Addresses deviant sexual practices (SEE TEVAL13A-17A)	**TTP13A** **1**	**TTP13B**	**TTP13C-D**
TTP14. Addresses motivation to change/attitudes towards victims, etc. (SEE TEVAL22A)	**TTP14A**	**TTP14B**	**TTP14C-D**
TTP15. Denial (SEE TEVAL24A)	**TTP15A**	**TTP15B**	**TTP15C-D**
TTP16.Violence (SEE TEVAL25A)	**TTP16A**	**TTP16B**	**TTP16C-D**
TTP17.Risk of re-offense (SEE TEVAL26A)	**TTP17A**	**TTP17B**	**TTP17C-D**

DOCUMENTATION OF GOALS AND METHODS USED TO ACHIEVE THEM

TTP19. Does the treatment plan or other document list specific goals for this offender and methods that will be used to achieve these goals. For example, an offender may have a goal to be educated about the risk of re-offense. Are specific methods for achieving this goal documented?

1 **Yes, <u>all</u> goals have objectives and methods**
2 **Yes, <u>at least half but not all</u> of the goals have objectives and methods**
3 **Yes, <u>some, but less than half</u>, of the goals have objectives and methods**
0 **No, there are <u>no objectives and methods to meet goals</u>**
4 **The offender <u>must progress through a specified program</u>. No individual goals are listed. The phases/modules cover issue areas.**

TREATMENT PLAN UPDATES *(not progress reports)*

TXPUP1. Has the treatment plan used by the current provider been updated since the offender has received care from the current provider?

0 **No updates**

9 **No treatment plan**
2 **Offender has only been with treatment provider a short time (State how long in weeks__ __) (TXUP1A)**
1 **Yes, updates have been done**

List the dates of updates to the plan the current provider has been using.			
Month __ __	**Day __ __**	**Year __ __**	**Plan update documents the offender's *progress* or *lack of progress*** **0=not at all** **2=somewhat** **1=extensively** **3=plan has been reviewed but there is no change in plan**

TXPUP3. IF THE OFFENDER HAS NO TREATMENT PLAN UPDATES, has the offender's progress or lack of progress in treatment IN THE LAST SIX MONTHS been documented in other areas of the file, e.g. progress reports, group notes, etc.

1 **Yes, there is one reference to the offender's progress in treatment in the last SIX MONTHS. Source:_____**
2 **Yes, there are 2 to 3 references to progress in treatment in the last SIX MONTHS. Source:_____**
3 **Yes, there are 4 or more references to progress in treatment in the last SIX MONTHS. Source:_____**
0 **No references to progress in treatment**
9 **Not applicable as the treatment plan has been updated**

SERVICES RECEIVED

TTXR1. Does the file indicate that the offender <u>received</u> treatment/services?

0 **No**
1 **Yes, IF YES COMPLETE THE TABLE BELOW**

Rating
0=No documentation that this service/tx was received/offender attended treatment
1=received or currently receiving tx or services as outlined in the plan
2=Service was offered to offender, but s/he did not fully participate
3=Service was offered to offender, but s/he did not follow up/attend service as contracted or recommended (offender did not participate at all)
4=cannot determine if service/tx was received

Treatment/Services Recommended (e.g., medication referrals, drug treatment, group therapy, etc)	**Rating**	**Documentation, e.g., referral slips, case notes, communications from other providers, etc.** **(CODE 2 REASONS**
TTX1A	TTX1B	TTX1C-D

TTX2A	TTX2B	TTX2C-D
TTX3A	TTX3B	TTX3C-D
TTX4A	TTX4B	TTX4C-D
TTX5A	TTX5B	TTX5C-D
TTX6A	TTX6B	TTX6C-D
TTX7A	TTX7B	TTX7C-D
TTX8A	TTX8B	TTX8C-D

TTXR2. If an offender did not attend or was tardy on a regular basis, or did not participate in treatment were consequences imposed?

1 Always
2 Sometimes
0 Never
8 Can't determine
9 Not applicable, offender always attended treatment

TTXR3-6 If consequences were imposed when the offender did not attend, etc., what (CODE UP T0 4) _____
_____
_____

Is documentation of any of the following in the file IN THE LAST SIX MONTHS	**1=yes 0=no (TXDOCA)**	**IF YES, HOW MANY TIMES WAS THIS DOCUMENTED 0 = 0 1 = 1-2 2 = 3 or more (TXDOCB)**
TXDOC1A-B. Clients treatment progress		
TXDOC2A-B. Clients lack of treatment progress		
TXDOC3A-B. Attendance (attended/not attended)		
TXDOC4A-B. Failed assignments		
TXDOC5A-B. Rule violations		
TXDOC6A-B. Specific Achievements		
TXDOC7A-B. Other:		

DOES THE TREATMENT PLAN/PROGRAM MATCH NEEDS

TMATCH1. Based on the information recorded above and your review of the file, does the level and intensity of treatment described in the active treatment plan match or program match offender needs as described in the MH SOS or other assessments? ***Provide an overall rating. Note: this is not an evaluation of the treatment provided but rather the treatment matches the needs.***

To a great extent 5 4 3 2 1 0 Not at All
8 Cannot determine. Why not?

_____
_____

You must document your rating: TMATCH1A-C (Code up to three reasons)

_____
_____
_____
_____
_____

RELAPSE PLAN/SAFETY PLAN

3.140 F.14 *A treatment provider shall require offenders to develop a written relapse prevention plan for preventing re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses*

TREL1. Does the file contain a relapse prevention plan as described above?

1 Yes
0 No
8 Can't determine
2 Relapse prevention plan appears to be in progress

Note: If there have been any safety plans for specific events, etc.:_____

_____

DENIAL

Guiding principles 1., 2., 3.5., 7., 8, 10, 11

3.620 When a sex offender in strong or severe denial must be in the community (e.g., mandatory parole), offense-specific treatment shall begin with an initial module that specifically addresses denial and defensiveness. Offense-specific treatment for denial shall not exceed six months.....

TDENIAL1. At the start of treatment, was this offender in denial (see treatment plan and SO MH evaluation)?

0 **No**
8 **Cannot determine**
1 **Yes**

TDENIAL2. Was treatment offered to the offender specifically addressing denial?

1 **Yes**
0 **No**
8 **Can't determine**

3.650 Offenders who are still in strong or severe denial and/or are strongly resistant after this six (6) month phase of treatment shall be terminated from treatment and revocation proceedings should be initiated if possible. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if revocation is not an option....

TDENIAL3. Was the offender still in denial six months after treatment started?

2 **Offender not in denial at the beginning of treatment**
1 **Yes**
0 **No**
8 **Can't determine**

TDENIAL4. If offender was in denial after six months, was treatment terminated?

2 **Offender not in denial at six months**
1 **Yes**
0 **No**
8 **Can't determine**

TDENIAL 5. Were sanctions/consequences imposed for denial at the end of six months or throughout the six month period that the offender was in denial?

1 **Yes, what were they:_____**
_____(Code up to 4) TDENA-D
0 **No**
8 **Can't determine**
9 **Not applicable**

THE POLYGRAPH DATA COLLECTION FORM

P1. Does the treatment provider file contain polygraph examiner reports?

1 Yes
0 No

P2. Does the supervising officer file contain polygraph examiner reports?

1 Yes
0 No

Note the dates of reports (first to last), types of polygraphs, their results, and where they were found below:

#	Mo	Day	Year	Type of Polygraph 1=Disclosure 2=Maintenance 3=Specific Issue	Result 1=DI 2=NDI 3=INC	Location Found	
						Supervising Officer File	Treatment Provider File
POLY1	P1MO	P1DA	P1YR	P1TYPE	P1RSLT	P1SUP	P1TX
POLY2	P2MO	P2DA	P2YR	P2TYPE	P2RSLT	P2SUP	P2TX
POLY3	P3MO	P3DA	P3YR	P3TYPE	P3RSLT	P3SUP	P3TX
POLY4	P4MO	P4DA	P4YR	P4TYPE	P4RSLT	P4SUP	P4TX
POLY5	P5MO	P5DA	P5YR	P5TYPE	P5RSLT	P5SUP	P5TX
POLY6	P6MO	P6DA	P6YR	P6TYPE	P6RSLT	P6SUP	P6TX
POLY7	P7MO	P7DA	P7YR	P7TYPE	P7RSLT	P7SUP	P7TX

Did any of the polygraphs taken during THE LAST TWO YEARS contain pre or post test admissions/question pertaining to the following:

1=yes 0=no 8 Cannot determine	Pre-Test Admissions	Post-Test Admissions
QCC3A-B Masturbation to thoughts of a child		
QCC4A-B Arousal to physical contact with a child		

Did polygraphs taken during THE LAST TWO YEARS contain the following or similar questions. If so, did the offender score deceptive, non -deceptive or inconclusive on the question?

	How many polygraphs with this question in the (LAST TWO YEARS)	How many deceptive answers to question (LAST TWO YEARS)	How many non-deceptive answers to question (LAST TWO YEARS)	How many inconclusive answers to question (LAST TWO YEARS)
QCC5A-DMasturbation to thoughts of a child				
QCC6A-DArousal to physical contact with child				
QCC7A-D Similar question:				

Disclosure/Sex History Polygraphs

P8. Has the offender received a disclosure polygraph(s)?

1 Yes
0 No
8 Can't determine

P9. Did the disclosure polygraph process (INCLUDING THE PRE AND POST TESTS) contain a question regarding sexual contact with children?

2 No disclosure polygraph
0 No
8 Cannot determine
1 Yes

Did the offender pass the disclosure polygraph that included a question on sexual contact with children?

1 Yes
0 No
8 Cannot determine

P10. Did the offender reveal new victims/behaviors (previously unknown) during the disclosure/sex history polygraphs?

0 No
2 Offender did not have a disclosure polygraph
8 ***Cannot determine***
1 ***Yes***

If Yes, what were their ages? _____
&

COMPLETE CHART BELOW

Age Group **PD1 TO PD8**	**Was offender under supervision for current offense 1=yes 0=no 8=can't tell PD1SUP - PD8 SUP**	**Gender 1=male 2=female 3=both PD1GEN TO PD8GEN**	**Relationship 1=family 2=pos/trust 3=acquaint 4=stranger (insert as many as apply) PD1REL TO PD8REL**	**Penetration Offense 1=yes 0=no PD1MPEN-PD8MPEN PD1FPEN-PED8FPEN**		**Fondling/ Frottage 1=yes 0=no PD1MFON-PD8MFON PD1FFON PD8FFON**		**Other 1=yes 0=no PD1MOTH-PD8MOTH PD1FOTH-PD8FOTH**		**For Other insert types of behaviors – Use numbers from Chart (*) Up to 5 PD1PAR1 –23 PDP8PAR1-23**	**At time of offense was the offender 1=juvenile 2=adult 3=juvenile and adult 4=not avail V1OFF-V8OFF**
				male	female	male	female	male	female		
0-5											
6-9											
10-13											
14-17											
18+											
Eld/Risk											
Unknown											
Not against specific persons											

P11. If victims disclosed in the <u>disclosure polygraph</u> were children in age groups other than those previously known, did the supervision plan change?

0 **No**
8 **Cannot determine**
1 **Yes (What were their ages?) __ __, __ __, __ __, __ __, __ __, __ __ P11A-F**

How did the supervision plan change?_____
_____
_____

P11 G-J

P12. If at least one <u>disclosure polygraph</u> was deceptive or inconclusive, were there overt changes in the supervision plan because of this deception?

1 **Yes**
2 **Yes, changes occurred because of one deceptive polygraph, but there was more than one deceptive polygraph**
3 **No disclosure polygraph was administered**
0 **No**
8 **Can't determine**
11 **CONTINUE ON NEXT PAGE**

If 1 or 2 is circled, how was supervision changed because of deceptive/inconclusive disclosure polygraphs (NOTE IF THE RESPONSE WAS TO DECEPTIVE OR INCONCLUSIVE)?
_____
_____
_____
_____

P12A-D, P12DEC, P12INC

P13. Did results of the disclosure polygraph(s) result in disclosure of current risks (other than new victims) that were previously unknown?

1 **Yes**
0 **No**
8 **Can't determine**

What types of new risks were revealed?_____
_____
_____
_____

P13A-E

P14. Was there a change in monitoring/supervision because these new risks?

1 **Yes**
2 ***Yes more monitoring on some risks but some risks not addressed***
0 **No**
8 **Can't determine**

If monitoring was changed because of risks, what types of monitoring/supervision changes occurred?
_____
_____
_____
P14A-D

MAINTENANCE POLYGRAPHS

P15. Has the offender been administered maintenance polygraph(s) in the last two years?

8 **Cannot determine**
1 **Yes, how many_____(P15A)**
0 **No**

P15b. Is a maintenance polygraph scheduled?

1 **Yes**
2 **Maintenance polygraph not scheduled because offender has not passed disclosure polygraph**
0 **No**
8 **Cannot determine**

P16. Did the maintenance polygraph(s) address sexual contact with children?

1 **Yes, all maintenance polygraphs addressed contact with children**
2 **At least one maintenance polygraph addressed sexual contact with children.**
How many maintenance polygraphs contained these types of questions?____P16A.
0 **No maintenance polygraphs addressed sexual contact with children**
8 **Cannot determine**
12 **CONTINUE ON NEXT PAGE**

P16B. If 1 or 2 is circled, Did the offender pass the maintenance polygraphs that included a question on sexual contact with children?

1 **Yes, the offender passed all the maintenance polygraphs with questions with questions addressing sexual contact with children**
2 **The offender passed some of these maintenance polygraphs. How many?_____P16C**
0 **No**

8 Cannot determine

P17. Did the offender reveal new victims (previously unknown) during ANY OF THE <u>maintenance polygraphs</u>?

0 No
2 Offender did not have a maintenance polygraph
8 Cannot determine
1 Yes

<u>If Yes</u>, what were their ages? _____

P17A-F
COMPLETE CHART BELOW-<u>COMBINE INFORMATION ON ALL</u> MAINTENANCE POLYGRAPHS

Age Group **PM1-PM8**	**Was offender under supervision for current offense** **1=yes** **0=no** **8=can't tell** **PM1SUP-PM8SUP**	**Gender** **1=male** **2=female** **3=both** **PM1GEN-PM8GEN**	**Relationship** **1=family** **2=pos/trust** **3=acquaint** **4=stranger** **(insert as many as apply)** **PM1REL-PM8REL**	**Penetration Offense** **1=yes** **0=no** **PM1MPEN-PM8MPEN** **PM1FPEN-PM8FPEN**		**Fondling/ Frottage** **1=yes** **0=no** **PM1MFON-PM8MFON** **PM1FFON-PM8FFON**		**Other** **1=yes** **0=no** **PM1MOTH-PM8MOTH** **PM1FOTH-PM8FOTH**		**For Other Insert types of behaviors, Use numbers from Chart (*) UP TO 5** **PM1PAR1-23** **PM8PAR1-23**	**At time of offense was the offender** **1=juvenile** **2=adult** **3=juvenile and adult** **4=not avail** **PM1OFF-PM8OFF**
				male	female	male	female	male	female		
0-5											
6-9											
10-13											
14-17											
18+											
Eld/Risk											
Unknown											
Not against specific persons											

P18. If victims disclosed in the <u>maintenance polygraph</u> were children in age groups other than those previously known, did the supervision plan change?

0 No
8 Cannot determine
1 Yes

How did the supervision plan change?_____
_____
_____

P18A-D

P19. If at least one <u>maintenance polygraph</u> was deceptive or inconclusive, were there overt changes in the supervision plan because of this deception?

1 Yes
2 Yes, changes occurred because of one deceptive polygraph, but there was more than one deceptive polygraph and no changes resulted from the others
0 No
8 Can't determine

If 1 or 2 is circled, how was supervision changed because of deceptive <u>maintenance polygraphs?</u>

_____
_____
_____
_____

P19A-D

P20. Did results of the <u>maintenance polygraph(s)</u> result in disclosure of new risks (other than new victims)?

1 **Yes**
0 **No**
8 **Can't determine**

What types of new risks were revealed?_____
_____
_____
_____

P20A-E

P21. Was there a change in monitoring/supervision because these new risks?

1 **Yes**
2 **Yes, more monitoring on some risks but some risks not addressed**
0 **No**
8 **Can't determine**

If monitoring was changed because of risk, what types of monitoring/supervision changes occurred?

_____
_____
_____
_____
_____

P21A-D

SPECIFIC ISSUE POLYGRAPHS

P22. Has the offender been administered a <u>specific issue polygraph(s)</u> in the last two years?

1 **Yes, how many__ __P22A**
0 **No**
8 **Cannot determine**

P23A-D. For what reason was the offender administered <u>specific issue polygraph(s)</u> in the last two years? (Circle all that apply)

1 **No specific issue polygraphs**
2 **Denial on previous polygraph**
3 **New accusations**
4 **Other, explain:**
5 **Other, explain:**
6 **Other explain:**

P24. Did specific issue polygraph(s) address sexual contact with children?

1 Yes, all specific issue polygraphs addressed sexual contact with children
2 At least one specific issue polygraph addressed sexual contact with children.
How many specific issue polygraphs contained these types of questions?____P24A
0 No specific issue polygraphs addressed sexual contact with children
8 Cannot determine

P24B. If 1 or 2 is circled, did the offender pass the specific issue polygraphs that addressed sexual contact with children?

1 Yes, the offender passed all the specific issue polygraphs that addressed sexual contact with children
2 The offender passed some of these specific issue polygraphs. How many?_____P24C
0 No
8 Cannot determine

P25. Did the offender reveal new victims (previously unknown) during specific issue polygraphs?

0 No
2 Offender did not have a specific issue polygraph
8 Cannot determine
1 Yes

If Yes, what were their ages? _____

P25A-F
IF YES, COMPLETE CHART BELOW COMBINING INFORMATION ON ALL SPECIFIC ISSUE POLYGRAPHS

Age Group PS1-PS8	Was offender under supervision for current offense 1=yes 0=no 8=can't tell PS1SUP-PS8SUP	Gender 1=male 2=female 3=both PS1GEN PS8GEN	Relationship 1=family 2=pos/trust 3=acquaint 4=stranger (insert as many as apply) PS1REL PS8REL	Penetration Offense 1=yes 0=no PS1MPEN PS8MPEN PS1FPEN PS8FPEN		Fondling/ Frottage 1=yes 0=no PS1MFON PS8MFON PS1FFON PS8FFON		Other 1=yes 0=no PS1MOTH PS8MOTH PS1FOTH PS8FOTH		For Other Insert types of behaviors, use numbers from Chart (*) PS1PAR1-23 PS8PAR1-23	At time of offense was the offender 1=juvenile 2=adult 3=juvenile and adult 4=not avail PS1OFF-PS8OFF
				male	female	male	female	male	female		
0-5											
6-9											
10-13											
14-17											
18+											
Eld/Risk											
Unknown											
Not against specific persons											

P26. If victims disclosed in the specific issue polygraph were children in age groups other than those previously known, did the supervision plan change?

0 No
8 Cannot determine
1 Yes

How did the supervision plan change?_____
_____
_____

P26A-D

P27. If any <u>specific issue polygraph</u> was deceptive or inconclusive, were there overt changes in the supervision plan because of this?

1 **Yes**
2 **Yes, changes occurred because of one deceptive or inconclusive polygraph, but there was more than one deceptive polygraph and no changes resulted from the others**
0 **No**
8 **Can't determine**

If 1 or 2 is circled, how was supervision changed?
_____
_____
_____
_____

P27A-D AND P27DEC, P27INC

P28. Did results of the <u>specific issue polygraph(s)</u> result in disclosure of new risks (other than new victims)?

1 **Yes**
0 **No**
8 **Can't determine**

What types of new risks were revealed?_____
_____
_____
_____

P28A-E

P29. Was there a change in monitoring/supervision because these new risks?

1 **Yes**
2 **Yes, more monitoring on some risks but some risks not addressed**
0 **No**
8 **Can't determine**

If monitoring was changed because of risk, what types of monitoring/supervision changes occurred?
_____
_____
_____
_____

P29A-D

Note: for the following questions, refer to notes on training regarding appropriate questions for polygraph.

6.160 G. All test questions must be formulated to allow only Yes or No answers.

6.111 In order to design an effective polygraph examination and adhere to standardized and recognized procedures, the relevant test questions should be limited to no more than four (4) and shall (these are listed in the table below):

Answer the following about the test questions in THE LATEST polygraph report:

TEST QUESTIONS	Yes	Some what	No
Were simple, direct and short as possible (no run on sentences, etc.)			
Included legal terminology			
Included mental state or motivation terminology			
Were clear (e.g., did not allow for multiple interpretations)			
Each question referenced only one issue			
Presupposed knowledge on the part of the examiner			
Used easily understood language			
Could be easily answered yes or no			
Tested on written statements			
Included emotionally laden terminology (such as rape, molest, murder, etc).			

6.190 Examiners shall issue a written report. The report must include factual, impartial, and objective accounts of the pertinent information developed during the examination, including statements made by the subject. The information in the report must not be biased, or falsified in any way. the examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process. All polygraph examination written reports must include (these are listed in the table below):

Review THE LATEST polygraph report in the offender's file to determine if the following information was included:

	Yes	No
Date of test or evaluation (insert date here: Mo___Day__Yr___)		
Name of person requesting exam		
Name of examinee		
Location of examinee in the CJS (probation, parole, etc.)		
Reason for examination		
Date of last clinical examination		
Examination questions and answers		
Any additional information deemed relevant by the polygraph examiner (e.g., examinee's demeanor)		
Reasons for inability to complete exam (write N/A across response columns if exam was completed)		
Information provided by the examinee, outside the exam		
Results of pre-test and post-test examination		

APPENDIX D:

TYPES OF SERVICES DELIVERED

TREATMENT SERVICES

Treatment Services

- Group Therapy
- Individual Therapy
- Couples Therapy
- Phase 1 Group
- Drug & Alcohol Treatment
- Family Sessions
- Polygraph Process Group
- Study Hall
- Anger Management
- Contract Violation Group
- Introduction to Treatment
- Sex History Disclosure Group
- Victim Empathy
- Aftercare Group
- Covert Group
- Failed Sex History Group
- Partner, Family, and Friend Group
- Process Group
- Relapse Prevention Group
- Sex Abuse Cycle
- Additional Journalling
- Arousal Conditioning
- Cognitive Class
- Community Meetings
- Cycle Group
- Deceptive Polygraph Group
- DOC group
- DV Treatment
- Grief Counseling
- Homework
- Intensive Group Treatment
- Medication
- Medium Containment Group
- Peer Group
- Phase Movement Group
- Psychology Evaluation
- Sex Education Class
- Sexual Abusers
- Significant Other Education Classes
- Social Skill Group
- Staffing
- Staffing With Support Person
- Substance Abuse Education
- Therapy
- Wrap-up Peer Group

APPENDIX E:

SAFETY PLANS FOR SPECIFIC EVENTS

SAFETY PLANS FOR SPECIFIC EVENTS

- Birth of child
- Birthdays
- Bowling league
- Brothers wedding
- Canon City
- Church
- Contact w/children
- Cripple Creek
- Daily community safety plan
- Drive in movies
- Family visits
- Friends
- Frisbee golf
- Graduation
- Gym
- Holidays:
    - 4th of July
    - Christmas
    - Halloween
    - Labor Day
    - New Year's
    - Thanksgiving
- Internet usage
- Keep myself safe in the community
- Mothers memorial
- New living situation
- New years party
- Play golf
- Pool party
- Roommates
- Swimming pool
- Taking children to dinner
- Teach golf
- Travel plans for lectures
- Travel out of state
- Trip to Pueblo to see Attorney
- Visit daughter in hospital
- Visit with child
- Work deliveries

APPENDIX F:

SITUATIONS FOR WHICH CONSEQUENCES AND SANCTIONS ARE IMPOSED

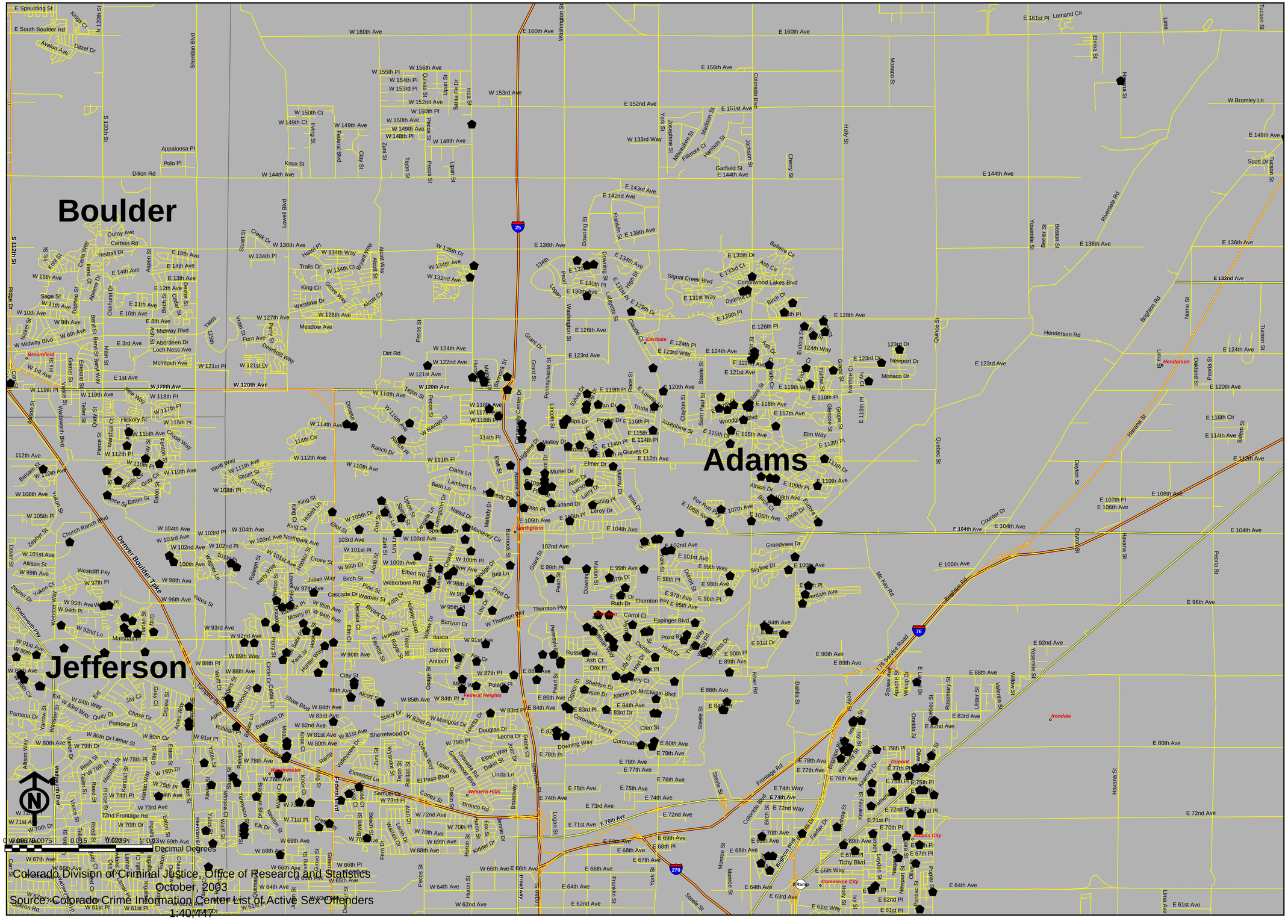
Table A: Responses from Treatment Provider Telephone Surveys about the types of situations they impose consequences for and the sanctions they impose

n=64	**TYPES OF SITUATIONS** ***(Providers seemed to try and link the sanction with treatment)*** **For example: Pornography, internet use**	**TYPES OF SANCTIONS** **For examples: No access to computers, remove computer**
25.4% (16)	Lack of progress in treatment, lack of participation, lack of compliance	• Range of sanctions from homework to termination • Homework, journaling, extra assignments, behavior impact projects, study hall • No progression forward, regress in treatment • Deniers group • Suspension from treatment, program probation (90-120 days) • Termination from treatment
34.9% (22)	Late or absent from treatment	• Increase treatment, individual sessions, make up groups, process in groups • Pay for missed appointments/sessions, charge for lateness • Study hall
9.4% (2)	Lying, withholding information, unaccountable	• Increase polygraphs • Meet w/ offenders support group/family • Staff, meet w/ team and discuss
1.6% (1)	Outbursts in group	• Anger management group/class • Warning letter/written reprimand
6.3% (4)	Unapproved contact with children, suspicion of contact with children	• Call PO, notify probation, discuss w/ probation, written notice to probation • Increase sup/monitoring • Loss or privileges • Increase polygraphs
4.8% (3)	Incidental contact, collateral contact with children	• Verbal reprimand/ban contact • Call PO, notify probation, discuss w/ probation, written notice to probation
3.2% (2)	Deviant fantasies	• Homework, journaling, extra assignments, behavior impact projects
4.8% (3)	Dangerous behavior, high risk behavior, aggressive behavior	• Call PO, notify probation, discuss w/ probation, written notice to probation • Anger management group/class • Staff, meet w/ team and discuss

4.8% (3)	Disclosures	• Call PO, notify probation, discuss w/ probation, written notice to probation • Contract violation group
6.3% (4)	Drinking, drug use, hot UAs	• Drug &Alcohol treatment • UA's or increased UA's, antabuse
14.3% (9)	Violations of the treatment contract	• Contract violation group • Call PO, notify probation, discuss w/ probation, written notice to probation • Termination of treatment
3.2% (2)	Unapproved locations	• Restricted outings, structured free time • Curfew • Home detention, house arrest, ankle monitor, EHM • Modify Terms & Conditions
1.6% (1)	Sexualizing the therapist	• Call PO, notify probation, discuss w/ probation, written notice to probation • Staff, meet w/ team and discuss
1.6% (1)	Violations of safety plan	• Call PO, notify probation, discuss w/ probation, written notice to probation • Staff, meet w/ team and discuss • Contract violation group
1.6% (1)	Probation violation/revocation	• Call PO, notify probation, discuss w/ probation, written notice to probation • Staff, meet w/ team and discuss • Contract violation group • Revocation • Send to court, send to see judge • Weekend in jail, work-enders • Jail, prison, arrest
3.2% (2)	Domestic disturbances/DV	• Remove offender fm relationship, withhold visitation • SLA, change living arrangement • Anger management group/class
1.6% (1)	Employment issues	• Job search log • Community service
1.6% (1)	Non-payment for treatment	• Monetary fine (goes to victim fund) • Pay for missed appointments/sessions, charge for lateness
1.6% (1)	Intentional invalidation of polygraph, not working to pass poly	• No progression forward, regress in treatment • Deniers group • Increase polygraphs

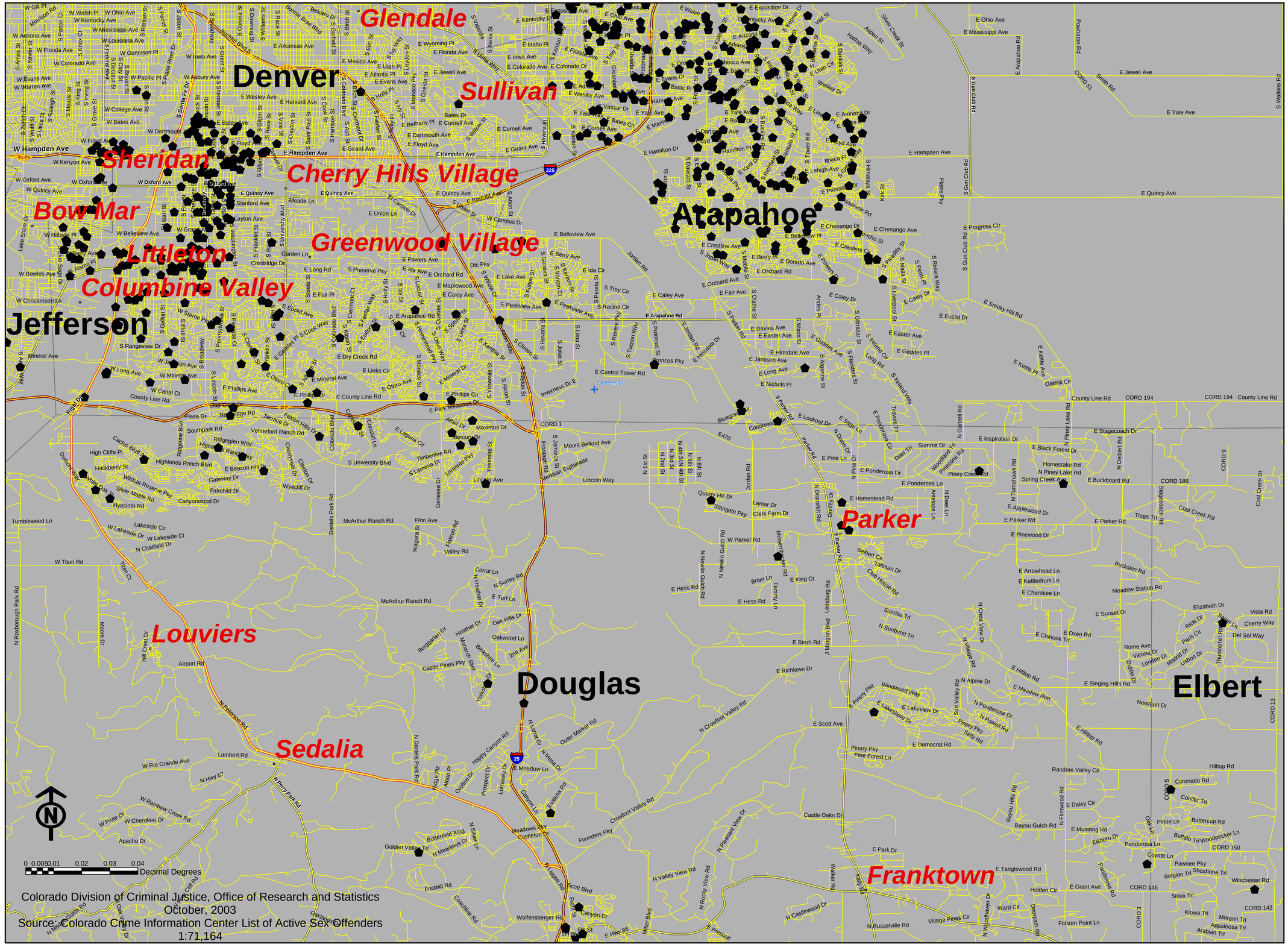
3.2% (2)	Victimization	• Call PO, notify probation, discuss w/ probation, written notice to probation • Staff, meet w/ team and discuss • Contract violation group • Revocation • Send to court, send to see judge • Weekend in jail, work-enders • Jail, prison, arrest

Registered Sex Offenders in Adams County as of 1/31/2003 (N=589)

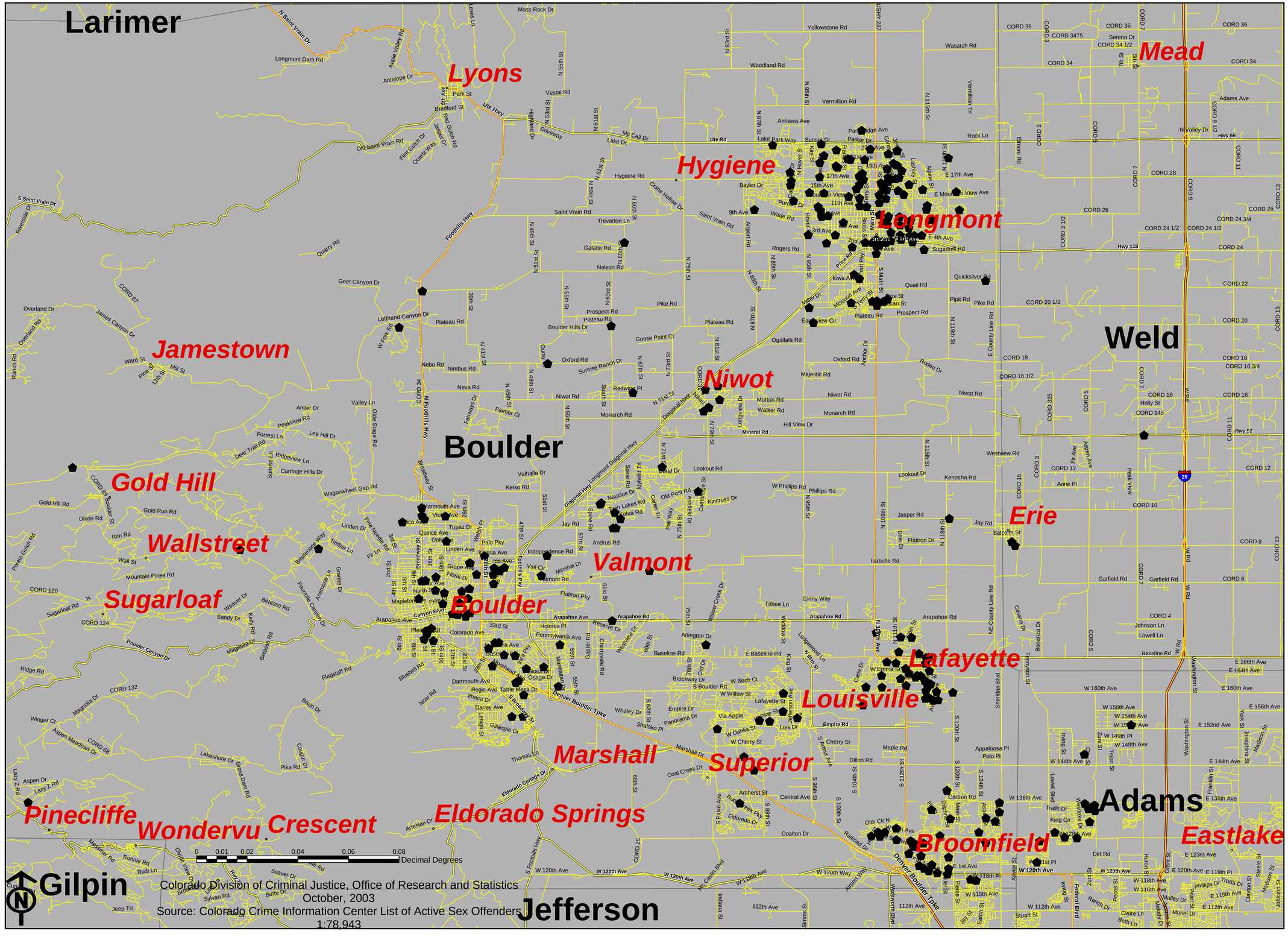


Colorado Division of Criminal Justice, Office of Research and Statistics
October, 2003
Source: Colorado Crime Information Center List of Active Sex Offenders

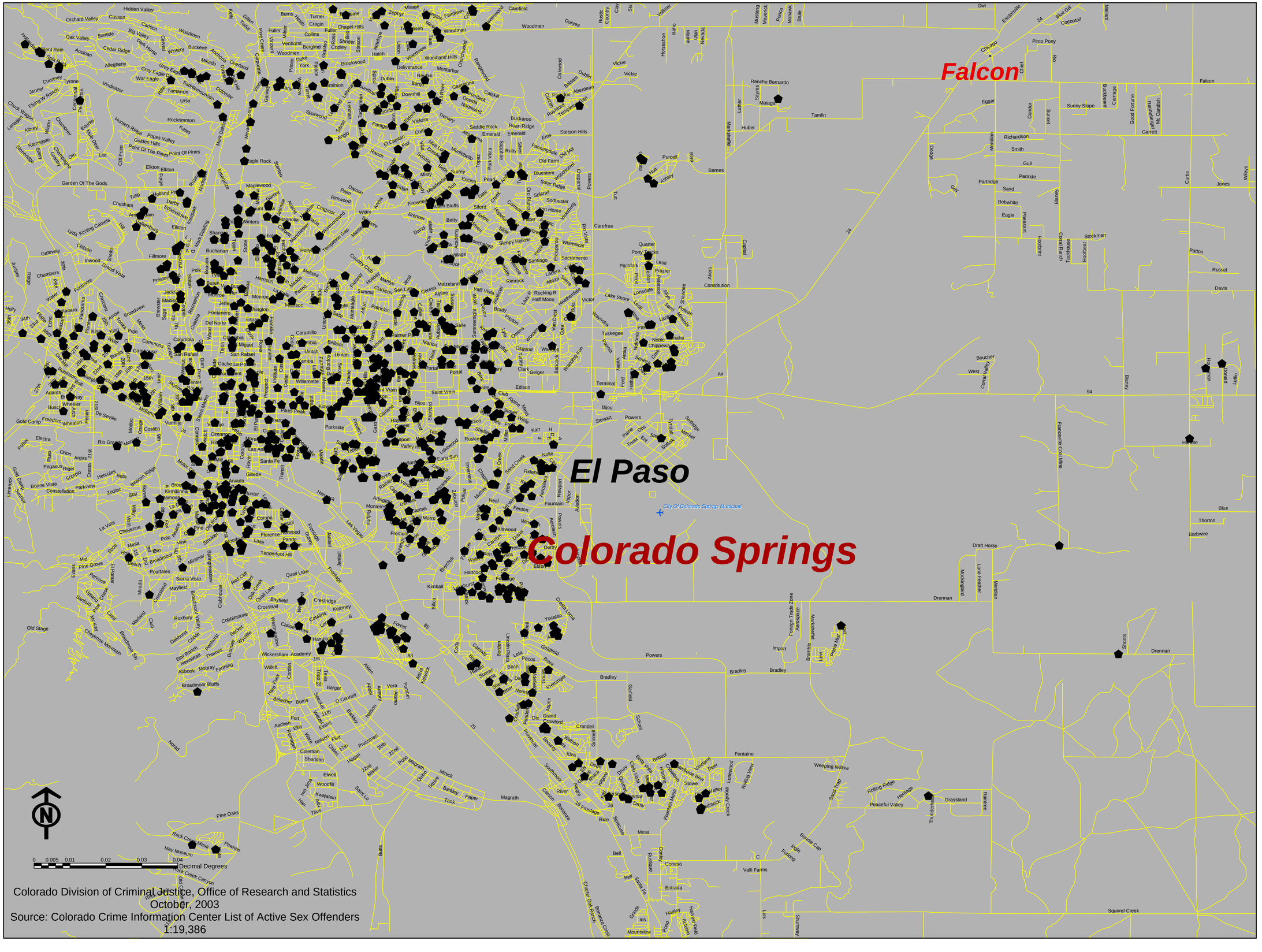
Registered Sex Offenders in Arapahoe County as of 1/31/2003 (N=1037)



Registered Sex Offenders in Boulder County as of 1/31/2002 (N=385)

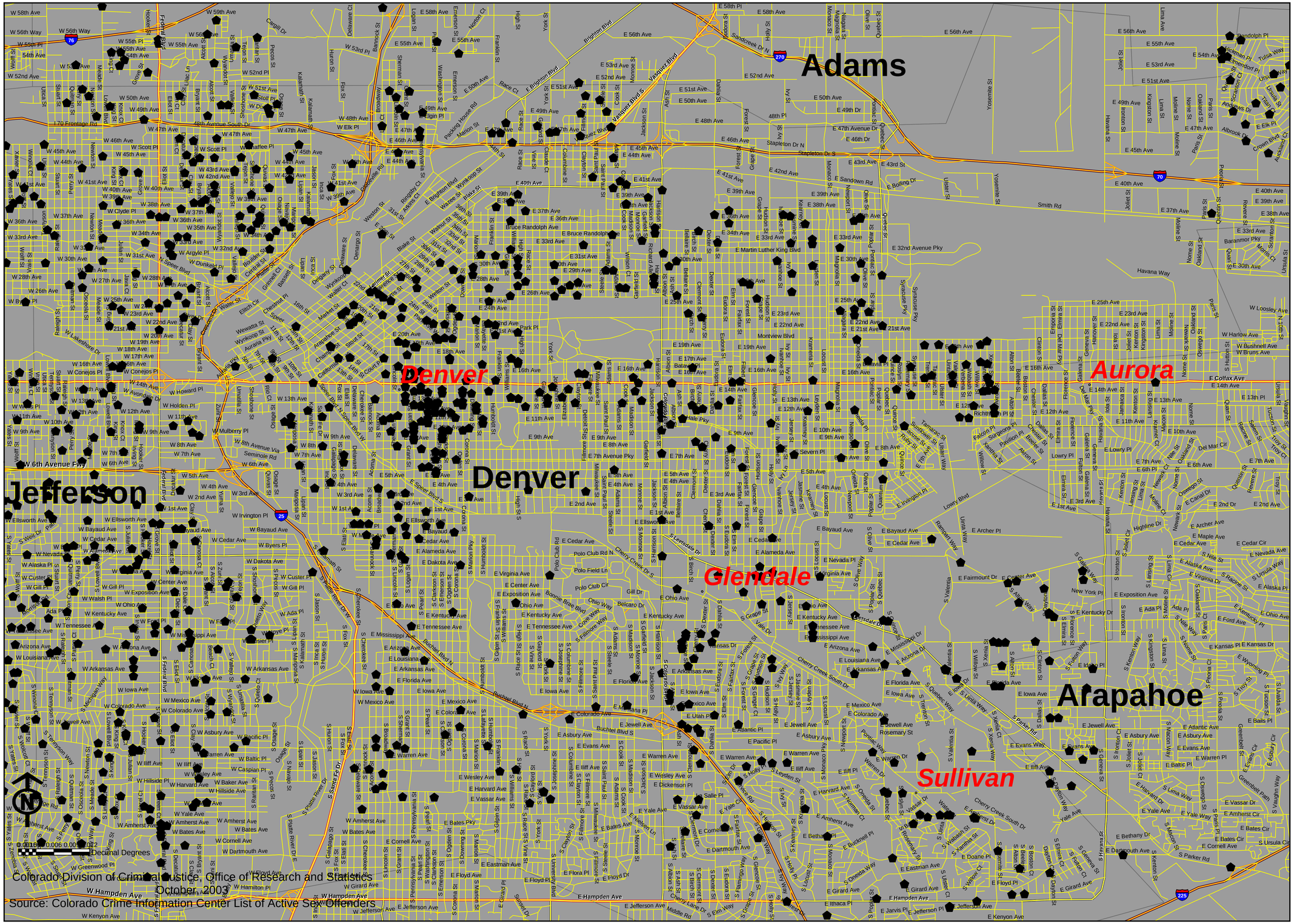


Registered Sex Offenders in El Paso County as of 1/31/2003 (N=1339)

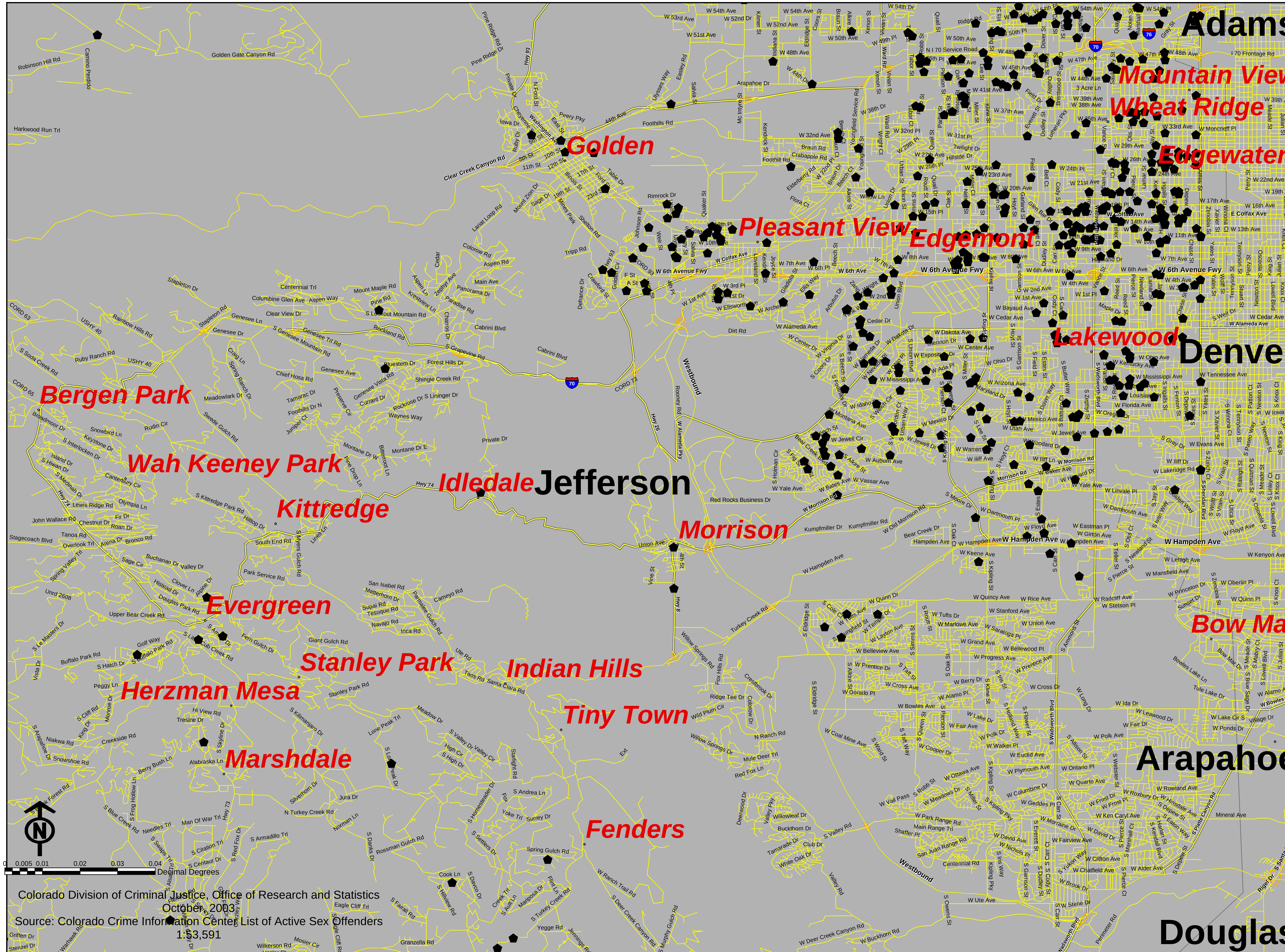


Colorado Division of Criminal Justice, Office of Research and Statistics
October, 2003
Source: Colorado Crime Information Center List of Active Sex Offenders
1:19,386

Registered Sex Offenders in Denver County as of 1/31/2003 (N=1347)



Registered Sex Offenders in Jefferson County as of 1/31/2003 (N=731)

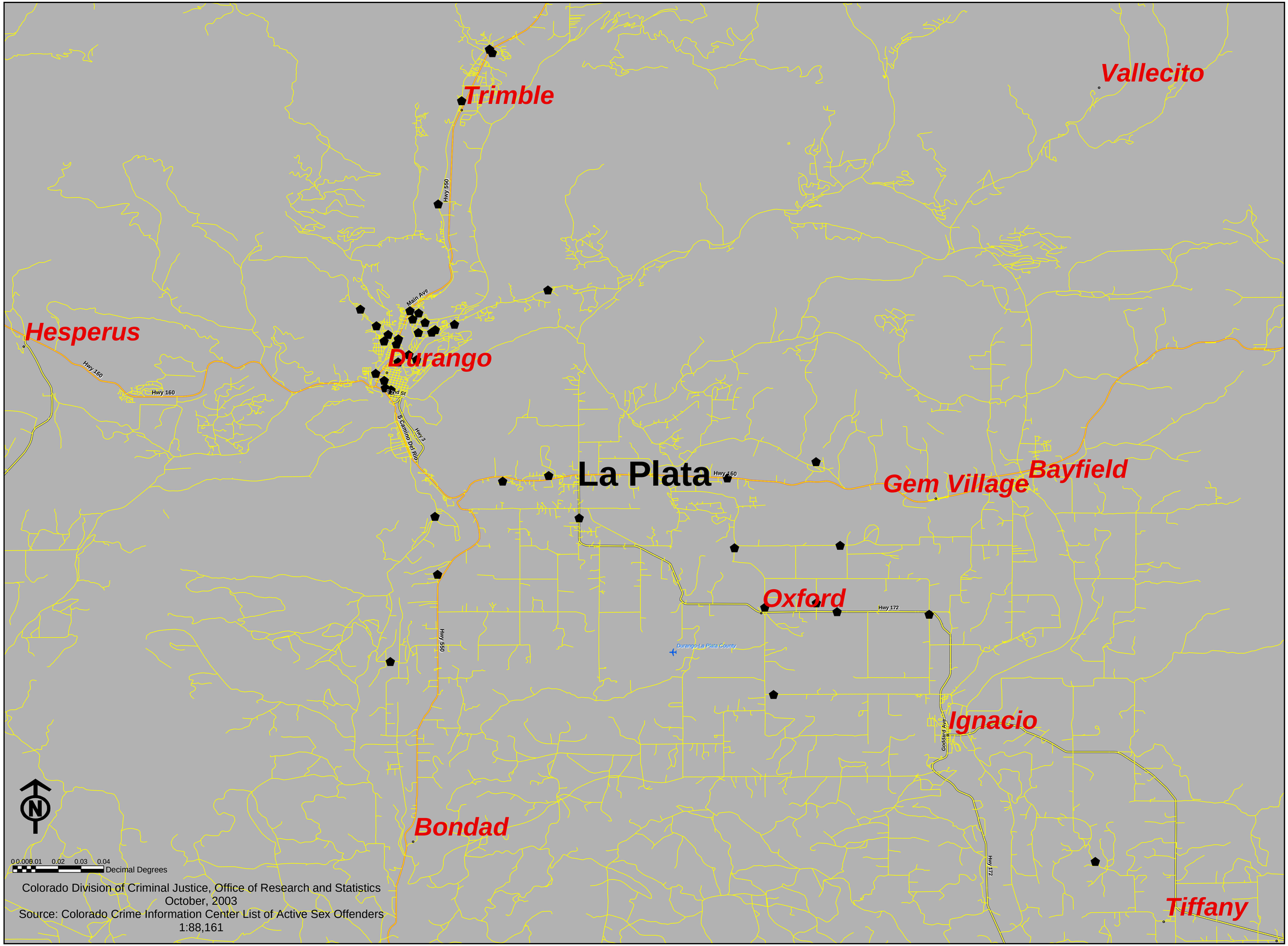


Colorado Division of Criminal Justice, Office of Research and Statistics
October, 2003
Source: Colorado Crime Information Center List of Active Sex Offenders
1:53,591

Legend

- Registered Sex Offenders
- Jefferson County Streets

Registered Sex Offenders in La Plata County as of 1/31/2003 (N=65)

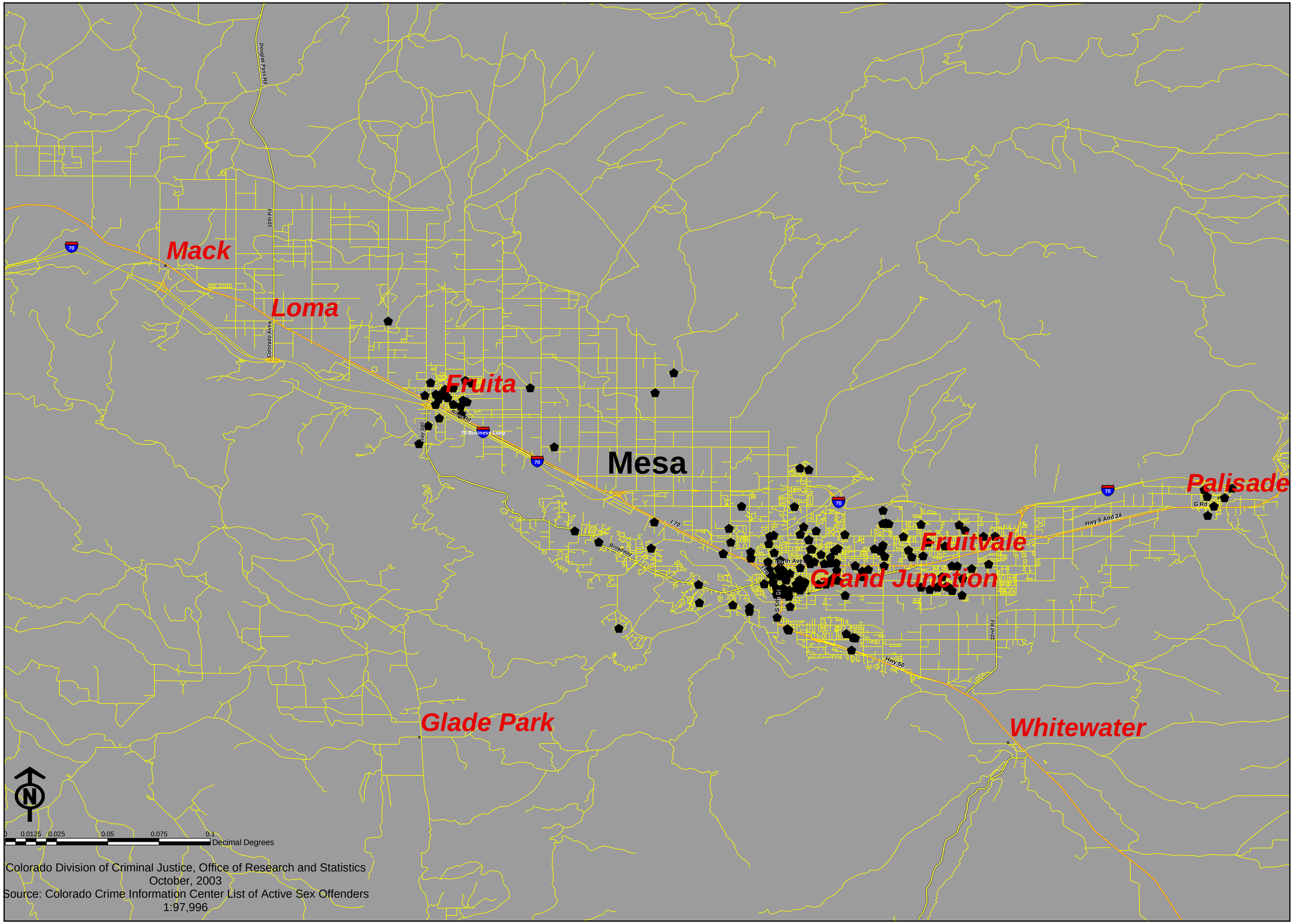


Colorado Division of Criminal Justice, Office of Research and Statistics
October, 2003
Source: Colorado Crime Information Center List of Active Sex Offenders
1:88,161

Legend

- Registered Sex Offenders
- La Plata Streets

Registered Sex Offenders in Mesa County as of 1/31/2003 (N=259)

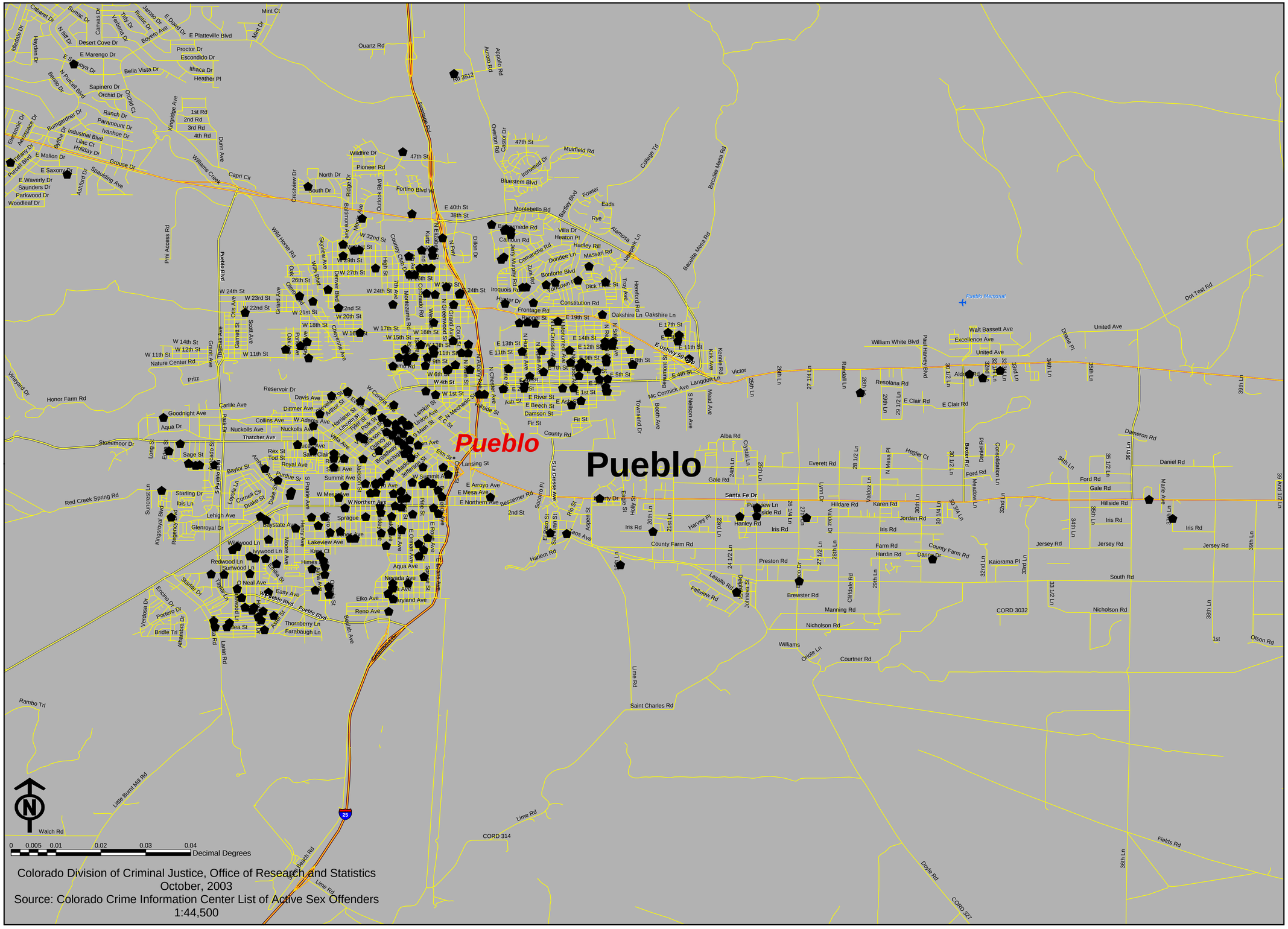


Legend

- Registered Sex Offenders
- Mesa County Streets

Colorado Division of Criminal Justice, Office of Research and Statistics
October, 2003
Source: Colorado Crime Information Center List of Active Sex Offenders
1:97,996

Registered Sex Offenders in Pueblo County as of 1/31/2003 (N=433)



APPENDIX H:

STUDIES THAT HAVE TRACKED SEX OFFENDERS

Table A: Tracking Adult Sex Offender Recidivism Rates: Compiling Information from Several Colorado Studies

Outcome	System component • Length of follow-up	N Rate	Comments	Info Source
Revocation (may include new crime)	Probation • 12 months	221 41%	• Early implementation of the *Standards and Guidelines.*	DCJ's 1998 Risk scale study
	Parole • 12 months	47 53%		DCJ's 1998 Risk scale study
	Community corrections • 24 months	30 50%	o 1997-1998; most offenders were in a special sex offender program in Colorado Springs	DCJ's CC study
	Prison: PAROLE and NO treatment • Duration of parole	1310 48%	• The *Standards and Guidelines* emphasize the value of supervision. • Parolees with no prison treatment were 3x more likely to get revoked back to prison.	DCJ's prison study
	Prison: PAROLE and Intensive TREATMENT • Duration of parole	115 16%		DCJ's prison study
	Probation • Duration of probation	405 31%	FY 2001 case outcomes	2003 Office of Probation Services
Rearrest Rate: Any Crime	Community corrections • 24 months	N 38%	o 38% rearrested for any misdemeanor or felony	DCJ's CC study
	Prison: NO parole, NO treatment • 24 months	1,264 48%	• Treatment in DOC improved outcomes by 30%. • These offenders were not subject to parole supervision and so did not receive community supervision and treatment.	DCJ's prison study
	Prison: NO parole, intense prison TREATMENT • 24 months	140 31%		DCJ's prison study
	Prison: PAROLE, NO treatment, released on parole • 24 months	655 34%	• Parole includes community treatment and supervision per the *Standards and Guidelines* . • Those who participated in prison treatment were half as likely to be rearrested.	DCJ's prison study
	Prison: PAROLE, intense prison TREATMENT • 24 months	78 17%		DCJ's prison study

	Probation • While under supervision	405 6.4%	FY02 cases terminated: Felony or misdemeanor while under supervision	2003 Office of Probation Services
Rearrest Rate: Violent Crime	Prison: NO parole, NO prison treatment • 24 months	1264 22%	• Parole supervision combined with prison treatment improved outcome by 38%. • The combination of supervision and treatment is a focus of the *Standards and Guidelines.* • Parole alone is less effective than when combined with intensive prison treatment. • The best outcomes are associated with the combination of treatment and supervision. • Sex offenders on parole *without prison treatment* were 5x more likely to get arrested for a violent crime.	DCJ's TC study
	Prison: PAROLE, intense prison TREATMENT • 24 months	140 16%		DCJ's prison study
	Prison: PAROLE, NO prison treatment • 24 months	655 13%		DCJ's prison study
	Prison: PAROLE, intensive prison TREATMENT • 24 months	78 2.6%		DCJ's prison study
Refiling Rate: New Crime	Probation ISP • 12 months	118 7.6%	• This is overall, not sex offenders specifically, for FY 2001	Judicial's 2002 probation recidivism report
	Prison: NO parole, NO treatment • 24 months	1264 28%	• Even without community supervision and treatment, intense treatment in prison reduced the refilling rate 36%. • Intense prison treatment cut the rate of new filings by nearly half.	DCJ's prison study
	Prison: NO parole, intense prison TREATMENT • 24 months	140 17%		DCJ's prison study
	Prison: PAROLE, NO prison TREATMENT • 24 MONTHS	655 14%		DCJ's prison study
	Prison: PAROLE, intense prison TREATMENT • 24 months	78 6.4%		DCJ's prison study

	Probation o 12 months	254 2.9%	o 7 new criminal filings for those who successfully completed probation	2003 Office of Probation Services